

IMPLEMENTATION OF THE MEDICARE DRUG BENEFIT

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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IMPLEMENTATION OF THE MEDICARE DRUG BENEFIT

WEDNESDAY, MAY 3, 2006

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:05 p.m., in room 1100, Longworth House Office Building, the Honorable Nancy L. Johnson (Chairman of the Subcommittee), presiding.

[The advisory and second advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 26, 2006
HL-15

CONTACT: (202) 225-3943

Johnson Announces Hearing on Implementation of the Medicare Drug Benefit

Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on implementation of the new Medicare prescription drug benefit known as Part D. **The hearing will take place on Wednesday, May 3, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing will recess at 12:00 p.m. and reconvene at 2:00 p.m. if necessary.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witnesses only. Witnesses will include Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan, a representative from the Social Security Administration (SSA), as well as representatives of groups affected by the new benefit. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On December 8, 2003, the President signed into law the Medicare Modernization Act (P.L. 108-173) (the MMA), which created a new Part D benefit in the Medicare program to provide coverage for outpatient prescription drugs. Prior to the law, most outpatient drugs were not covered by Medicare and many seniors who did not have prescription drug coverage through another source either individually assumed this financial burden or went without prescription drugs because of the cost. According to CMS, starting in January 2006, millions of Medicare beneficiaries began receiving prescription drugs through the new program. Since that time, almost a quarter of a billion prescriptions have been filled, and many seniors have availed themselves of discounts through their drug plans, and many have saved.

Under the program, beneficiaries could purchase standard coverage, alternative coverage with actuarially equivalent benefits or enhanced coverage. In 2006, standard coverage is a \$250 deductible, 25 percent coinsurance for costs between \$251 and \$2,250, and catastrophic coverage after out of pocket expenses of \$3,600. Once the beneficiary reaches the catastrophic limit, the program pays all costs except for nominal cost-sharing. Low income subsidies are provided for persons with limited assets and incomes below 150 percent of the poverty level. Coverage is provided through prescription drug plans or Medicare Advantage prescription drug (MA-PD) plans. The program relies on private plans to provide coverage and to bear some of the financial risk for drug costs; Federal subsidies are provided to encourage participation. Premiums are determined through a bid process and plans compete based on premiums, benefits and negotiated prices.

To date, hundreds of private insurance plans are contracting with CMS. Accordingly, Medicare beneficiaries have a number of options to choose from, including benefit plans provided by Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and stand alone drug plans. In addition, under the MMA, a 28 percent subsidy is provided to employers and unions whose plans at

least equal the standard coverage for retiree drug costs between \$250 and \$5,000, and this is excludable from taxation. Employers are also permitted to structure their benefits around Part D coverage and enroll retirees in Part D plans.

There are currently about 43 million Medicare beneficiaries. Although the Part D drug benefit program is voluntary, about 27 million Medicare beneficiaries are directly benefiting as a result of this program. The latest figures show more than 8 million Medicare beneficiaries have decided to sign up for stand alone prescription plans, up from about 3 million in January, and these numbers continue to grow. Finally, the MMA federalized the costs of about 5.8 million “dual eligible” beneficiaries, those who are eligible for both Medicare and Medicaid. Problems with the transition for this population were reported and continue to be by beneficiary groups, pharmacists and some States.

The Centers for Medicare and Medicaid Services have already begun the process of reaching out to private drug plans for the 2007 plan year. It remains to be seen how beneficiaries and plans will respond to the first year of the program and the upcoming May 15 enrollment deadline.

In announcing the hearing, Subcommittee on Health Chairman Nancy Johnson stated, “Today more seniors than ever before have access to affordable prescription drug coverage through the Medicare drug plan, and more seniors are signing up every day. The Medicare drug benefit is the biggest expansion of the program since it was created 40 years ago. Today more than 27 million Medicare beneficiaries have drug coverage; including 8 million who have signed up for stand-alone drug plans. During this hearing, we will examine how this significant new program is being implemented and discuss with Medicare beneficiaries, federal officials and health care providers how we can improve the drug benefit going forward.”

FOCUS OF THE HEARING:

The hearing will focus on implementation of the new Part D benefit.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “109th Congress” from the menu entitled, “Hearing Archives” (<http://waysandmeans.house.gov/Hearings.asp?congress=17>). Select the hearing for which you would like to submit, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, completing all informational forms and clicking “submit” on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Wednesday, May 17, 2006. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.



ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 01, 2006
HL-15 Revised

CONTACT: (202) 225-3943

Change in Time for the Hearing on Implementation of the Medicare Drug Benefit

Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on implementation of the new Medicare prescription drug benefit known as Part D, previously scheduled to begin at 10:00 a.m. on Wednesday, May 3, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, ***will now be held at 2:00 p.m.***

All other details for the hearing remain the same. (See Health Advisory No. HL-15, dated April 26, 2006).

Chairman JOHNSON OF CONNECTICUT. Good afternoon, everyone. The hearing will come to order. Today, I am pleased to chair this hearing on the Medicare drug benefit which is so dramatically changing the lives of our seniors. Today, more seniors and disabled people than ever before have prescription drug coverage, and it is because of the Medicare drug benefit. This is a momentous time in Medicare's impressive history. The largest expansion of the program is improving seniors' access to prescription drugs and thereby fundamentally improving their health and their financial security.

The Medicare momentum we are witnessing is undeniable. Last year, the Administration set a goal of having 30 million Medicare beneficiaries enrolled in the drug benefit. Last month, they tapped 27 million, and hundreds of thousands are signing up weekly. In fact, just today, 27,382 new enrollees have entered the Medicare drug plan. Of the remaining seniors, there are another 9 million that already have drug coverage; for example, those over 65 who are active employees in the public and private sector, members of TRICARE or participants in other programs. Seniors and the disabled are filing more than 93 million prescription drug prescriptions a month, an average of 3 million prescriptions a day. More importantly, once enrolled, seniors are happy, happy with the benefits provided. The Association for Advancement of Retired People (AARP), the largest organization representing seniors, found that 8 of 10 seniors enrolled in the program said that it met or exceeded their expectations. A Kaiser Foundation poll finds that 3 out of 4 seniors enrolled in the Medicare drug plan are satisfied with their plan and are not having trouble getting the drugs they need.

Seniors are giving this benefit their stamp of approval. This is the largest benefit expansions in Medicare's history. So, it is not

surprising that there have been some implementation pitfalls along the way. What is commendable, however, is how quickly the Centers for Medicare and Medicaid Services (CMS) has taken ownership of the problems and addressed the issues within the first 2 months of the program's functioning through close, collaborative, consultative action with plans, pharmacists, States and other stakeholders. As the program matures, it will need continued refinement, but enrollment numbers and survey after survey show undeniable momentum. The real story is how seniors across the country are signing up and saving money. It is misleading to focus on only the refinements, however, when seniors like Gail Blazewski from Cheshire, Connecticut is saving \$2,000 a year. That is the real story that the Medicare prescription drug benefit is telling across the country.

I ran into a senior in my district recently who said to me Part D is the difference between my staying in my home and my not being able to stay in my home. I can't tell you how grateful I have been for the work of the Congress and the work of the executive branch and their many, many partners all across the country, as I have seen senior after senior breathe a huge sigh of relief as the pressure of prescription drug cost is taken from their shoulders. I commend CMS for such a broad coalition of senior and advocate groups working to help seniors sign up. The AARP fielded a multi-million, quote, Reach Campaign. The National Association for the Advancement of Colored People (NAACP), the Nation's oldest civil rights group, not only launched a media campaign but an intense grassroots efforts to reach minority seniors and enroll minority seniors. Today, 70 percent of minority seniors are signed up, not just in the black community, but in the Hispanic community and in the Asian community.

CMS has 10,000 grassroots partners, and they have been conducting 1,800 enrollment events across the country each week and will do so right up to May 15, 2006. Additionally, CMS has increased resources to keep the wait times down and beneficiary support up at 1-800-Medicare and Medicare.gov website. To that end, I am very pleased to welcome Dr. Mark McClellan, Administrator of CMS. I appreciate, Dr. McClellan, how thoughtfully and effectively CMS has worked to implement this program. I commend your decision to join forces with thousands of partners across the country, frankly, an unprecedented public-private partnership in the history of my experience of Federal Government over many years. I appreciate the dedication of you, the employees at Medicare, the employees in the public and private sector, and all the volunteers who made it possible for so many seniors to sign up.

I look forward to your report made on the progress of the implementation of Medicare Part D benefit, the solutions found to the problems you encountered, the efforts you have made to prepare for the 2007 general enrollment and also the next steps, because Medicare Part D wasn't brought in to be part of Medicare just because we wanted to expand the benefit program, as important as that expansion. Medicare Part D will mature at the same time our knowledge of our chronic disease management demonstration projects mature and at the same time, we will have implemented a great number of preventive health benefits, and that is going to enable

us to take some very important next steps. I would like to hear your comments on that future as you conclude your remarks. Also, on the first panel is Beatrice Disman, Chairman of the Medicare Planning and Implementation Task Force at the Social Security Administration (SSA). The SSA has also addressed this issue with remarkable care, remarkable teamwork and remarkable outreach, and I appreciate your hard work and look forward to your report on how you are reaching the low-income seniors who are the most vulnerable and the most in need of good prescription drug coverage.

On the second panel, Susan Everett, North Carolina Regional Coordinator, Medicare Today, a partnership of more than 400 organizations, will testify to their efforts to inform seniors and enroll them in the new benefit. Susan will share experiences with working one on one with seniors enrolling on the new benefit. Next, we will hear from Heath Schiesser, President, Prescription Drug Plan, WellCare Health Plans, Inc. WellCare Health Plans, Inc. is offering three different prescription drug plans in all 50 States. He will speak to the role competition has played in providing high-quality benefits at a lower cost for seniors and taxpayers.

Also, Robert Hayes, President of the Medicare Rights Center, a consumer rights organization, will share his experiences with assisting seniors in enrolling in the Medicare drug benefit, especially those that could benefit from the low-income subsidy. Then, we will hear from Bill Wolfe, Vice President, Managed Care, Rite Aid Corporation, who will speak to the operations of the Medicare drug benefit since January and the actions that CMS has taken to facilitate this process. Finally, we will hear from Pam Grisnik, Owner, RX Express, Grove City, Pennsylvania. She will speak on the role of community pharmacists and the important role they have played in this new benefit. There are still seniors that have questions about the program and haven't enrolled. It is natural to have questions with a change this big. Every senior, especially those without drug coverage, should write down the drugs they take and talk to a counselor at 1-800-Medicare or at one of the many hotlines States are operating or at the local senior citizens center or Area on Aging.

They should not let questions about this program keep them from finding answers and saving money, like so many of their friends, family and neighbors. For years, Members of Congress talked about adding prescription drug benefits to Medicare. Today, right now, a Medicare prescription drug benefit is a reality. Thirty million seniors are benefiting from it, including 8 million who had no drug coverage before. This is a great, historic achievement for both the health and financial well-being of the seniors of America. Welcome, Dr. McClellan. Excuse me. First let me turn to Pete Stark, and then I will come to Dr. McClellan.

Mr. STARK. Thank you, Madam Chair. I am glad we finally got to holding this hearing and hope that we have the time to get into this question thoroughly. The Medicare Prescription Drug Program (PDP) is now forecast to cost us \$1 trillion over the next decade. I hope today we could look at what we have gotten for our money, and I suspect you will find that we haven't gotten very much for that \$1 trillion. CMS will declare a victory when they tell us that

more than 30 million people now have prescription drug coverage through Medicare or through a former employer and that nearly 6 million more are covered elsewhere. They won't tell you that they have lowered the goal from 40 million, reduced it by 10 million to 30 million, so that they can claim success.

I understand that Dr. McClellan, today, is going to declare normal at 103 million, and therefore, many of the seniors who were classified as sick are called instantly well. The "mission accomplished" that will be quoted from the deck of CMS is premature. As a matter of fact, I wondered where all of those people who counted weapons of mass destruction went when they were kicked out of the Defense Department, and there they are in CMS, finding out how many signed up in this drug bill. With fewer than 20 million enrolled in Part D and an additional 6 or 7 million in an employer plan subsidized by Medicare, some people have been newly covered under the law, and that is good. After all, it would be virtually impossible to spend the \$1 trillion and not help anyone.

I am very concerned that we have created this enormous, complicated, inefficient program that has eroded coverage for many of our most vulnerable and still not achieved the original goal of securing coverage for all. Millions of people covered by Medicare and Medicaid, the so-called dual eligibles, pay more today and are in plans that cover fewer medications relative to Medicaid. These are the people who are least able to afford this benefit reduction and that, to me, is not a very kind thing for us to be doing with the \$1 trillion. A recent survey by the Medicare Prescription Network, a group financed in part by the pharmaceutical companies, found that one out of five Medicare beneficiaries now pay more for their medication than they did before the law went into effect.

I can't say that I am surprised, that is what happens when you negotiate a law in secret, and follow the bidding for pharmaceutical industries is payback for campaign contributions. Unless you think I am entirely negative, I do want to take this opportunity to compliment CMS for several recent improvements. They have extended the enrollment deadline for people who are eligible for limited-income subsidies. They have also prohibited planned formulary changes from affecting medications their enrollees are currently taking. These are important changes. They will help, but more is needed.

I realize the Chair and others are not ready yet to do what we really need, and that would be a drug benefit in Medicare that would require the government to negotiate lower prices for the beneficiaries, just as we do for veterans today. That is why today I think we should only focus on a modest change, and that is to delay the May 15, 2006 enrollment deadline and the corresponding financial penalty. It is something we should all be able to agree on. It is something which we on the other side of the aisle would give complete credit to the Republicans for accomplishing, and I assure you we would have no problem with extending that under what we believe is the authority that CMS has to do this administratively.

We will be told by CMS that the May 15, 2006 deadline is important, because healthy people won't enroll without a deadline. I agree that a deadline at some point is necessary, but May 15 just doesn't seem to be the appropriate date, given all the confusion, the

complexity, and the errors. For example, the Government Accountability Office (GAO) report—and, Madam Chair, I would like to make the GAO report that was released this morning a part of the record. We had hoped that they would be here to testify, but we could put their report in the record.

Chairman JOHNSON OF CONNECTICUT. If the gentleman would yield, I would be happy to include their report in the record. Unfortunately, they could not brief us on it before, which is why they didn't testify. They have to have the authority of those who asked for the report in order to brief others on it before they are released. You all know not to do that. I am happy to have it put in the record, and I am sure that we will all have our reasons to refer to it.

[The information is being retained in the Committee files.]

Mr. STARK. Sure, one of the things that they have showed is that for the people whom you have suggested call these numbers, that when people asked for the lowest costs, given a certain list of drugs, in 60 percent of the cases, 43 percent of the calls were unanswered or they received inappropriate responses, and 16 percent were inaccurate. That is a 60 percent failure rate. Of all the calls that they monitored, one-third of the beneficiaries received no answer, an answer that was incomplete, inaccurate or inappropriate. I don't think that is a record that we should rely on to adequately inform our seniors. These are fundamental tools that they need to guide them in the decision-making process. They certainly weren't adequate to let Secretary Leavitt's father make the right choice, and that hits pretty close to home.

The government, the Congressional Budget Office (CBO), has told us that the change we are asking would cost \$2 billion over 5 years. In a \$1 trillion program, that is chump change; and it would, in fact, increase this year's enrollment, according to the CBO, by about 1 million people and reduces the penalties for 7.5 million beneficiaries that they would pay over their lifetime—that penalty comes to the Treasury, so that would be no additional funding for the pharmaceutical industry, who would get 1 million more people to sign up. To me, that is a win-win. Nobody gets harmed. We pay a little more money to include these 1 million people and reduce the tax on 7.5 people. It seems to me that would be money well spent. I would also in conclusion, Madam Chair, like to ask unanimous consent that some of our full Committee, non-Subcommittee members, be allowed to participate in today's hearing.

Chairman JOHNSON OF CONNECTICUT. I would be happy to have them participate after the Subcommittee members and if it doesn't exhaust the witnesses' time; if the witnesses' time isn't exhausted by the Subcommittee members.

Thank you, Mr. Stark. As I recognize Dr. McClellan, let me just note that, Pete, in your district, 83 percent of the seniors were signed up by the middle of April. In my district, only 62 percent of the seniors were signed up by the middle of April. I clearly have a lot of work to do, but I am glad to see that 83 percent of yours are signed up.

Mr. STARK. If the gentlelady would yield, half of the people who belong—live in my district—belong to one plan, Kaiser Permanente. So, they were automatically switched. That is sign A.

Chairman JOHNSON OF CONNECTICUT. That is great. You will also see as we start this hearing, a chart that shows the number of eligible Americans signed up for other kinds of subsidy programs, Medicaid, food stamps, Slimby, Quimby, the Earned Income Tax Credit, just so we can put into context the achievement that has been accomplished in 125 days in regard to signing up seniors into the Part D subsidy. Dr. McClellan.

STATEMENT OF MARK MCCLELLAN, M.D., Ph.D., ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. MCCLELLAN. Thank you very much, Chairman Johnson, Mr. Stark. Chairman Johnson and all Members of the Subcommittee, I appreciate the opportunity to update you on the new Medicare prescription drug coverage and especially the steps that we are taking to help people enroll as we enter the final days of the open enrollment period.

I want to thank my colleague, Bea Disman, and all of the staff at the SSA who have been working diligently to help our most vulnerable beneficiaries take advantage of the extra assistance in this program and who have collaborated with us every step of the way. I also want to take this opportunity to thank all of you who have participated in counseling and enrollment events across the country. I am very grateful for your personal assistance in driving awareness of Part D and helping millions of beneficiaries enroll in drug coverage to get savings and protection for the future.

Members of Congress have been an important part of our massive grassroots education effort, and I want this partnership to continue as we now begin to drive more effective use of Medicare's new preventive benefits and the drug coverage. This is the next step, Chairman Johnson, in turning Medicare from a traditional indemnity insurance program into a program that partners with our beneficiaries to improve their health and prevent unnecessary health care costs.

Millions of seniors and people with disabilities are already using this money to stay healthy, to gain peace of mind. Approximately more than 9 million beneficiaries have new individual prescription drug coverage since the program began. Several million individuals who, because they also qualify for Medicaid or the low-income subsidy, will also have low or no premiums in deductibles and cost-sharings, and many millions more have more extensive and more secure drug coverage building on the coverage they already preferred as a result of the drug benefit.

CMS estimates that almost 270 million prescriptions were filled under Part D during the first 3 months of 2006 for all of our beneficiaries with drug coverage, and numerous surveys show high rates of beneficiary satisfaction with their coverage.

Each week, hundreds of thousands of more beneficiaries are enrolling. We have already exceeded the initial enrollment expectations with more than 30 million beneficiaries with coverage, through Part D or a former employer, as of mid-April.

In addition, almost 6 million Medicare beneficiaries get drug coverage equal to Medicare's from other sources such as the Veterans Administration, and we want to work hard over the coming days to reach as many of the remaining 6 million. As close as possible. That is close to 96 percent of all Medicare beneficiaries. Half of those remaining are beneficiaries with limited incomes who we will continue to reach in the months ahead with expanded partnerships with SSA and outside organizations.

We have worked with the plans, the pharmacists, the States and hundreds of other partners around the country to educate beneficiaries and their caregivers about their choices, to help people understand how to make decisions based on cost, coverage, convenience, and peace of mind. We put in place many outreach resources to support these efforts.

While the vast majority of beneficiaries are already getting the savings security of drug coverage, again, we are working to reach as many more as possible between now and May 15, and that would put us at the 90-percent-or-above range, with many of those left having continuing opportunities to enroll.

To spread out any last-minute rush to enroll, CMS and our partners are undertaking a major effort to encourage beneficiaries to take advantage of the assistance now. In the past month, there have been more than 1,900 events per week across the country to provide beneficiaries with personalized help so they can understand their coverage options and make a confident decision about enrollment.

Not only is enrollment way up, costs are down and benefits are better than expected as a result of competition. Beneficiaries are able to enroll in plans that meet their needs far better than a one-size-fits-all benefit package and a single drug formulary could do. The result is coverage that serves beneficiaries well and costs less.

Over 90 percent of beneficiaries have opted for plans other than the standard statutory benefit design. They have enrolled in plans with low or no deductibles, flat copayments for covered drugs, and in many cases, coverage through the coverage gap.

Consequently, even though the new drug coverage is offering better benefits, it is costing much less for beneficiaries, taxpayers, and States than had been anticipated. The passage of the Medicare Modernization Act (MMA) (P.L. 108-173), the creation of the prescription drug benefit, posed some real changes for us in awareness, education and operational implementation that are unprecedented in scale and scope since the onset of the Medicare program 40 years ago.

Before implementation of the drug benefit, we provided most information directly to beneficiaries using traditional tools, including the Medicare and You handbook, 1-800-Medicare and our Web site, medicare.gov. Now, these are important pieces of information, but with the passage of the MMA we saw a need to improve and diversify our tools and to develop new strategies to reach a wider audience and to target hard to reach populations, including rural areas and minority communities.

In addition to print, radio, and television advertisements, we have a multipronged approach to raise awareness and assist bene-

ficiaries and their caregivers in making decisions about prescription drugs.

During 2004, we began reaching out to develop partnerships, and now we have a network that is incredibly diversified and committed, with more than 10,000 local partners. For several months, we held training sessions around the country to educate our partners about the benefit structures and the enrollment tools so that they could help us raise awareness and educate enrolled beneficiaries.

We recognize that to achieve the promise of the MMA we need to reach all segments of the Medicare population, especially underserved populations and those with language and cultural barriers. To reach them, including minority, low income, limited English-speaking, rural and homebound populations, we entered into a contract with the National Association of Area Agencies on Aging. Our strategies included strategy with community network-based organizations and nine national aging organizations with local affiliates to conduct outreach to low-income populations.

We developed specialized campaigns for the African American, Hispanic, American Indian and Asian American, and Pacific Islander communities, using new partnerships, creating materials in other languages, and doing specialized, targeted, paid media campaigns.

We are pleased that this is paying off with enrollment in minority populations that is running ahead of the national average. I think that is probably unprecedented.

We appreciate your participation in outreach, and we welcome your continued involvement as we work to reach remaining beneficiaries. Altogether we have hosted over 22,000 events since January. Chairman Johnson, as you mentioned this extensive grassroots-level partnership is unprecedented. There are many people all over the country, where they live and work and play and pray. It has enabled us to reach beneficiaries who otherwise might not have gotten the support they needed to enroll, and it has helped millions make a decision about Medicare coverage already.

It has helped personalize Medicare in a way we could never do from our national offices. I think this will be a lasting and fundamental change in the way that Medicare works.

I do want to spend a minute talking about the importance of our customer service and support. It is always a top priority at CMS to ensure that beneficiaries and our partners get accurate and timely information. We have handled more than 22 million calls between November 15 and April 24 of this year, and the agency takes great care in answering these calls promptly and providing accurate and useful information to callers. That is why we have ongoing and extensive and continuous monitoring improvement activities to make sure we are providing the most effective customer support possible.

We have worked diligently to improve the wait times and to ensure accurate information is available in a timely manner to those seeking assistance. We have ongoing monitoring programs of actual beneficiary calls, which evaluate a random sample of hundreds of actual calls on an ongoing basis every month. It has found that calls to 1-800-Medicare in 2006 have been answered accurately 93

percent of the time. Actual calls, 93 percent of the time answered accurately.

This high accuracy rate is reflected in the high rates of overall satisfaction from 1-800-Medicare callers. We also do regular contact and follow up with a random sample of the beneficiaries who actually call us. I am pleased to say that CMS customer satisfaction surveys indicate that of the bulk of callers who interact with our customer service representatives, 87 percent are satisfied with their experience.

Our Web site, *medicare.gov*, has also been visited more than 829 million times in the past 4 months. Many consumer experts like Consumer Reports, Jane Bryant Quinn, and Terry Savage of the Chicago Sun-Times all recommend using *medicare.gov* as a useful tool to get information about drug plans.

With this array of tools available, and the incredibly diverse and unprecedented scale and scope of our outreach activities around them, I am confident that we can reach more beneficiaries than have ever been possible before to help them take advantage of Medicare benefits.

Now, I would like to make special mention of the pharmacy community before I conclude. They are the linchpin of the drug benefit and have been tremendous in helping us. We are working hard to meet the demands of this new program, and so we will continue to take steps to support pharmacists, like supporting the creation of new computer standards and new approaches to recognizing and promoting high-quality pharmacy services.

I want to thank you again for the opportunity to discuss our progress during the first 4 months of the drug benefit. This has been a very exciting time for CMS, as we now have many new and important relationships that we are going to continue to strengthen for future outreach and education aimed at continuous improvement and the quality of care and health for the Medicare population.

While we are pleased that millions of Medicare prescriptions are being filled every day now, we will continue to work to ensure every person with Medicare can use this coverage effectively.

I am happy to answer any questions you may have.

Chairman JOHNSON OF CONNECTICUT. Thank you, Dr. McClellan.

[The prepared statement of Dr. McClellan follows:]

**Prepared Statement of The Honorable Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare and Medicaid Services,
U.S. Department of Health and Human Services**

Chairman Johnson, Representative Stark, distinguished Members of the Subcommittee, thank you for the opportunity to update you on the new Medicare prescription drug coverage, and especially the steps we are taking to maximize enrollment as we enter the final days of open enrollment period. I also want to address the steps that we are taking concerning preparations for 2007 to make the prescription drug benefit program even better. I want to take this opportunity to thank those of you who have participated in CMS' enrollment events throughout the country. I appreciate your interest in this topic, but more importantly I am very grateful for your personal assistance and that of many of your colleagues in driving the awareness of and enrollment in Part D. Members of Congress have been an important part of this massive grassroots education effort and I am very hopeful that this partnership we have created can continue as we begin to drive greater awareness

and use of the prevention benefits which the Congress included in the Medicare Modernization Act (MMA).

More than 8 million beneficiaries have new individual prescription drug coverage since the program began and more than 93.8 million prescriptions were filled for these beneficiaries with drug coverage during March—averaging 3 million prescriptions filled per day. The vast majority of beneficiaries are using their coverage effectively and each week hundreds of thousands of beneficiaries are enrolling in the new program. CMS has already exceeded the enrollment target with more than 30 million beneficiaries with drug coverage through Part D or a former employer as of April 18, 2006. In addition, almost 6 million Medicare beneficiaries get drug coverage from other sources with prescription drug coverage such as the Department of Veterans Affairs equal to Medicare. This brings the total to approximately 36 million Medicare beneficiaries who are now receiving prescription drug coverage.

According to data collected through beneficiary satisfaction surveys, 84 percent of seniors enrolled in the Medicare prescription drug program are satisfied with their coverage and 52 percent say they are enjoying significant cost savings.¹ Further, a U.S. Chamber of Commerce study shows that 85 percent of enrollees say their plan covers the medicine they need and a study conducted by the Kaiser Family Foundation reveals that 82 percent of enrollees who have filled a prescription under the benefit reported having no problems.²

CMS worked with the plans, pharmacists, States, and hundreds of other partners leading up to the start of the drug benefit to educate beneficiaries and their caregivers about the their choices and to help people understand how to make decisions based on cost, coverage, convenience, and peace of mind. There are still twelve more days to enroll before the May 15, 2006 enrollment deadline for the year, and we need to help beneficiaries get the savings and security of prescription drug coverage now.

We have put into place many outreach resources to get the information to beneficiaries so they can enroll. To minimize an anticipated last minute rush to enroll, CMS is making a monumental effort to enroll beneficiaries as soon as possible. In the last month, there have been more than 1,880 events per week across the country to provide beneficiaries with personalized help so they understand the prescription drug coverage options available to them and so they can enroll in a plan. I know that you and other Members of Congress have been very helpful with events in your district as well. I have personally contacted many of the high enrollment plans to express my concern that they put adequate resources into their call centers. However, we know there will be a large number of enrollments as the May deadline approaches. While this may lead to longer wait times on both our call lines and plan sponsor lines, we have worked with the plans and we will make every effort to enroll everyone who wants to enroll. But to minimize problems, you should encourage your constituents to act now.

Millions of seniors and people with disabilities are already using this benefit to save money, stay healthy, and gain peace of mind. This includes several million individuals who, because they also qualify for Medicaid, or the low-income subsidy (LIS), will have very low or no premiums deductibles and cost sharing. CMS estimates that almost 270 million prescriptions were filled during the first three months of 2006 for all Medicare beneficiaries with drug coverage. Because of strong competition in the prescription drug marketplace, there has been slower growth in prescription drug inflation in recent years, due in part to increasing generic drug availability. Also, the proliferation of tiered co-payment drug plans and use of formularies have caused the use of generic drugs to increase and further slow drug spending growth. Consequently, the new Medicare prescription drug coverage is costing much less for beneficiaries, taxpayers, and the States than anticipated.

Beneficiaries are choosing plans that best meet their needs, leading to coverage that serves them well and costs less for them and for taxpayers. Enrollment data reveal that the vast majority of beneficiaries are choosing plans that offer benefits other than the standard option as defined in the law. They are choosing plans that have low premiums, no deductibles, fixed copays, and coverage in the gap. In fact, only 16 percent of prescription drug plan (PDP) enrollees chose the standard, statutory option and only 5 percent of Medicare Advantage prescription drug plan (MA-PD) enrollees chose the standard option. Beneficiaries are also often choosing plans with access to a broad range of drugs. Beneficiaries eligible for the low-income subsidy have a very comprehensive benefit, with no coverage gap and usually no deductible.

¹ U.S. Chamber of Commerce, April 25, 2006.

² Kaiser Family Foundation, April 25, 2006.

CMS anticipates that plan sponsors will consider current enrollment statistics when submitting their bids for 2007, and will limit their plan options accordingly. CMS' expectations for plan bids are outlined in the 2007 Call Letter, which I will discuss shortly.

We are hearing reports from our partners about the cost savings people with Medicare are experiencing. It is estimated that the Medicare drug benefit will pay on average about half of total drug spending in 2006 for seniors who are not eligible for extra help.

The beneficiaries who qualify for the low-income subsidy receive substantially greater assistance, with a benefit that will cover on average over 95 percent of their drug costs.

CMS and Our Partners have Raised Awareness Nationwide

With the passage of the Medicare Modernization Act of 2003 and the creation of the Medicare prescription drug benefit, the Congress posed awareness, education, and operational challenges to CMS unprecedented in scale or impact since the onset of the Medicare program more than forty years ago. Notwithstanding a short timeline, CMS has risen to the challenges as evidenced by the most recent enrollment numbers, which exceed our target. With the outstanding help of our partners, CMS has instituted a grassroots initiative across the country, with partnerships which we believe will last long after the May 15th enrollment deadline. We have an extensive partnership network with more than 10,000 local partners including senior organizations and centers, youth groups, churches, civic and social organizations and federal state and local government agencies.

Before implementation of the drug benefit, CMS provided most information directly to beneficiaries using the traditional tools, including the Medicare & You Handbook, 1-800-MEDICARE, and www.medicare.gov. However, with the passage of the MMA, CMS saw the need to improve our existing tools and to develop new strategies in order to reach a wider audience and to target specific hard-to-reach populations, including rural areas and minority communities. In addition to print, radio and television advertisements, CMS has a multi-pronged approach to raise awareness and assist beneficiaries and their caregivers in making decisions about prescription drug plans.

CMS knew from the outset that it was essential to provide beneficiaries with more hands-on assistance than was available in our traditional educational materials through outreach events and one-on-one training. This effort would have to be both a high-touch and high-tech outreach campaign, with high-tech resources like the personalized Plan Finder web tool for use by our partners and our beneficiaries, as well as high-touch efforts involving one-on-one personal contacts using an intricate web of grassroots partners collaborating and leveraging each other for the maximum benefit of people with Medicare.

In addition, rather than just reaching beneficiaries, CMS cast a wider net to reach caregivers, family and friends of beneficiaries.

During 2004, CMS began reaching out to develop partnerships, and now the network is incredibly diverse and committed. For several months, we held training sessions throughout the country to educate our partners about the benefit structure and the enrollment tools so they could help raise awareness, educate, and enroll beneficiaries. CMS provided special training for social service coordinators to help them counsel low-income seniors. CMS relied heavily on our partner organizations to work with beneficiaries on a one-on-one basis.

President Bush, Secretary Leavitt, and I, along with CMS' regional office staff, have traveled over 500,000 miles across the country in a mobile office bus to form grassroots partnerships that help people with Medicare make an informed decision about prescription drug coverage. About 70 percent of these mobile office stops have taken place in rural communities throughout the country. Many Members of Congress have served as honorary chairs for these events and we appreciate their involvement in forging over 240 grassroots community and statewide networks, each led by a community partner. The mobile office reached rural areas across the country to complement our dedicated funding for outreach to rural areas. Since January 1, 2006, 269 events have involved the participation of an elected official. We appreciate your participation in outreach and we welcome your continued involvement in activities to reach beneficiaries.

We have continued to work harder than ever to help beneficiaries and their loved ones learn about their drug coverage. Since January, CMS and its partners have hosted over 22,000 events. Our partner organizations are also providing personalized counseling by request to help beneficiaries enroll in a plan that best meets their needs. CMS worked with the Social Security Administration and various organizations to provide training and conduct outreach to beneficiaries who may qualify

for low-income assistance. In addition, we forged partnerships with other federal agencies, which have helped to disseminate information to beneficiaries, especially to those who might qualify for the low-income subsidy.

Also, CMS regional offices along with State Health Insurance Assistance Programs (SHIPs), senior advocacy organizations, and agencies on aging have held thousands of information and enrollment events. In fact, CMS has more than doubled its funding to SHIPs since 2003, recognizing the importance of SHIP assistance to beneficiaries. In 2004, CMS provided more than \$21 million and increased that to more than \$31 million in 2005. The funding level will remain high, even after the initial enrollment period for prescription drug coverage ends, to ensure that SHIP counselors will continue to play an important role in educating beneficiaries about the drug benefit and their plan options in the months ahead.

We recognized that to achieve the promise of the MMA we would need to reach all segments of the Medicare population, especially underserved populations and those with language and other cultural barriers. To target these hard to reach populations, including minority, low-income, limited English-speaking, homebound, and rural populations, CMS has a contract with the National Association of Area Agencies on Aging. Strategies included contracting with Aging Network community-based organizations and nine National Aging Organizations with local affiliates to conduct outreach to low-income populations. Thus, we developed specialized campaigns for the African American, Hispanic, American Indians, and Asian American Pacific Islander communities, utilizing new partnerships, creating materials in other languages, and doing specialized paid media campaigns.

In summing up a new set of outreach initiatives for African-American beneficiaries, Dr. Sandra Gadson, president of the National Medical Association, has described the importance of this targeted outreach to specific populations such as African American beneficiaries. "If we think we have a health disparity crisis in the African American community today, imagine if we do not succeed in enrolling the most needy of our eligible seniors and people with disabilities." She noted that many of the organizations she was working with had not supported the law, but that it was clearly time to put politics aside in helping people take advantage of the new coverage . . . coverage that for low income seniors, as Jim Firman, of the National Council on Aging has said, is the most important new health care benefit in 40 years.

These extensive, grassroots-level partnerships are truly unprecedented for the Medicare program. We are reaching out to people with Medicare, many people, all over the country . . . "where they live, work, play, and pray." It has completely changed awareness about the drug benefit, and has helped millions make a decision about Medicare coverage already. It has helped personalize Medicare in a way that we could never do from our national offices. And I believe this will be a fundamental and lasting change in the way that Medicare works. This has been a very exciting time for CMS as we now have many new important relationships which we will continue to nurture for future outreach and education efforts aimed at continuous improvement in the quality of health of the Medicare population.

In addition to events around the country, we have worked to enhance our traditional methods of outreach and education. For instance, CMS treats the *Medicare & You 2006* handbook, which is mailed to all 42 million beneficiaries and includes detailed information about the new prescription drug coverage, as a continuous quality improvement project. Every year, in an effort to make the handbook a valuable and understandable beneficiary resource that is straightforward and easy to read, CMS conducts consumer testing of the draft handbook at two separate stages. Additional testing is sometimes done for specific sections. CMS also solicits input from our partners, including Members of Congress.

CMS Prioritizes Customer Service to Our Beneficiaries and Our Partners

As always, customer service is a priority at CMS to ensure beneficiaries and our partners are given accurate, timely information. With implementation of a brand new part of Medicare, CMS understands that people with Medicare, their families, doctors, and pharmacists will have questions about the new Medicare drug benefit. CMS' 1-800-MEDICARE Call Center has customer service representatives (CSRs) available to answer Medicare questions 24 hours a day, seven days a week with assistance in English and Spanish and many other languages as well. CMS' helpline and www.medicare.gov have served as critical tools for beneficiaries, caregivers, and enrollment assistance centers to sign up for the prescription drug benefit.

CMS has handled more than 22 million calls between November 15, 2005 and April 24, 2006, and the Agency takes great care in answering these calls as promptly as possible and providing accurate, useful information to callers. Because of the great interest in the new drug benefit, call wait times have been longer than we

would like at times. CMS has worked diligently to improve the wait times caused in part by data translation problems to ensure accurate information is available in a timely manner to those seeking assistance. As shown in Figure 1, on average, callers have experienced wait times of less than two minutes from January to mid-April, with longer waits sometimes occurring during peak call periods.

Figure 1

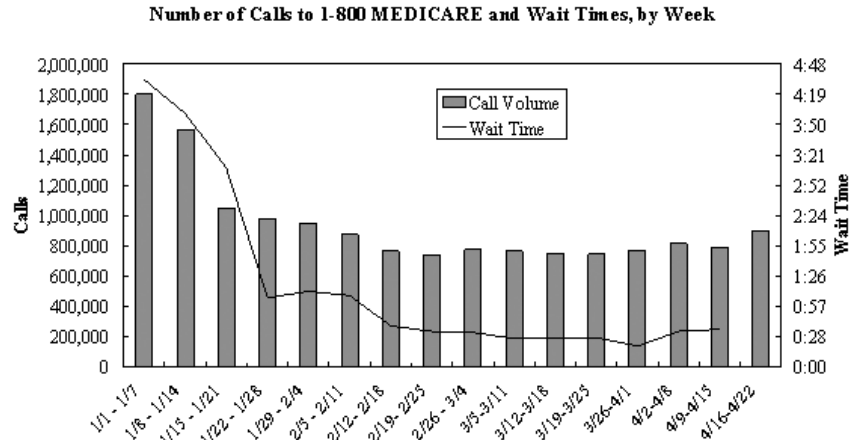


Figure 1: Call Volume and Wait Times to 1-800 MEDICARE

In order to help beneficiaries understand their drug plan choices and select the plan that best meets their needs, CMS increased the number of Customer Service Representatives (CSRs) from 3,000 in June of 2004 to as many as 7,800. We have also acquired additional infrastructure including telephone lines, workstations, and seats at call center sites. We have refined our CSR scripts by reducing redundant information, indexing scripts for quick access, and including probing questions to help the CSRs better identify the caller's concerns. In addition, all beneficiary toll-free numbers were moved to a single 1-800 number with a centralized Interactive Voice Response (IVR) system, allowing beneficiaries who call 1-800-MEDICARE to get answers to all Medicare questions through a single number, which has helped to channel calls appropriately and improve efficiency. Further, the IVR system was enhanced to incorporate more plain language, user-friendly functionalities, and synonyms for common beneficiary terms.

CMS has implemented a major enhancement through the use of Smart Scripts, which provide the CSRs with an easily followed path of responses to the most frequently asked questions. Smart Scripts are a new type of script that has hyperlinks built into the body of the text. When activated, these hyperlinks will take the CSR directly to related information about that subject. In addition, we have CSRs participate in the content workgroups for the actual development of scripts and job aides. CMS has also implemented a CSR feedback system and streamlined our approval process for updating the scripts in a timely manner to respond to the changing needs of our customers or to incorporate policy updates.

All CSRs receive one week of classroom training followed by two or three additional days of practice calls, simulation, quality monitoring, and follow-up coaching to ensure peak performance. CSRs are required to be certified with a written examination and test calls prior to taking live calls. CMS has taken steps to strengthen the call centers' capabilities and reduce wait times in order to address beneficiaries' concerns as they arise. CMS hired and trained additional staff to use the Prescription Drug Plan Finder tool to help beneficiaries get the information they need to enroll in a drug plan that suits their needs.

I am pleased to say that CMS customer satisfaction surveys indicate that the bulk of callers who interact with our CSRs, 87 percent, are satisfied with their experience. They are particularly pleased with how courteous and patient the CSRs are (rated at 97 percent). These responses came not only from people with Medicare, but also friends or relatives calling on their behalf, who made up 23 percent of callers during March 2006.

In addition to beneficiary satisfaction surveys, CMS also evaluates the 1-800-MEDICARE CSRs through “mystery shopping” to ensure they are providing accurate and complete responses to callers. “Mystery shopping” calls are made to CSRs by an independent specialized quality evaluation contractor who has developed scenarios and scripts to measure the CSRs on various topics to determine if CSRs are being “fully responsive.” A response is considered “fully responsive” if all key points are conveyed to a caller. We have consistently found that the information provided by the CSRs was fully responsive to the caller’s needs most of the time.

CMS’ Medicare Web site, www.medicare.gov, has also been a source of useful information for people with Medicare. Since the first of the year, our frequently asked questions have been accessed more than one million times. CMS also has responded to more than 19,000 e-mails received through the site, with 93 percent of them being resolved satisfactorily in the first response. In addition, the medicare.gov web site has been visited more than 829 million times since January 1, 2006.

With the array of educational tools available, I am confident that beneficiaries are getting the information they need to enroll. We have seen steady enrollment since November 15th.

CMS Works With Plans To Improve Their Customer Service

In addition to this significant strengthening of our 1-800-MEDICARE capabilities, we have issued guidance to the plans instructing them to increase the numbers of CSRs in their own call centers and take other necessary steps to provide timely and effective responses to inquiries from enrollees and health professionals. Plans have responded and reported significant increases in the number of CSRs in their call centers, and as a result, plan performance has improved.

While many plans are now providing timely phone access, some have not responded adequately. Therefore, CMS has increased monitoring of plans’ call center activities to help assure a high level of performance. We are surveying all prescription drug plans to assess whether they provide correct information to beneficiaries and pharmacists within a reasonable time. We expect continuing improvements as we address systems and data transfer issues. The 2007 Call Letter provides specific wait time metrics to which the plans must adhere, which I will outline shortly.

CMS Provides Caseworkers for One-on-One Counseling

While millions of prescriptions are being filled for people with Medicare, CMS is very concerned about those individuals who are encountering difficulties at the pharmacy counter. This is certainly distressing for those individuals and their caregivers.

CMS has established a system to help resolve urgent issues on a case-by-case basis. CMS has hundreds of trained caseworkers who are working as rapidly as possible to resolve urgent issues to help ensure that people with Medicare get their prescriptions filled. CMS urges people with Medicare or their family members who are having difficulties to call 1-800-MEDICARE, and if necessary, their case will be forwarded to our caseworkers. Urgent cases have high priority for rapid resolution.

While the number of individual cases is small in comparison to the millions of prescriptions and individuals who are successfully receiving their prescriptions, CMS is committed to ensuring that every individual receives his or her needed medicines, is properly identified, and is charged the appropriate copays.

CMS Takes Steps To Identify Areas of Concern

While considerable progress has been made, change of this magnitude in such a short time span is bound to encounter some difficulties. CMS is very concerned about anyone who has experienced problems in obtaining their medicines. We make no excuses for the problems. They are important, they are ours to solve, and we are finding and fixing them. We have and are continuing to take action to address issues so that all beneficiaries enrolled in a Medicare prescription drug plan can obtain their medications without incident. CMS also has been correcting data transmission problems between Medicare, health plans, pharmacists, and the States.

CMS developed the Complaints Tracking Module (CTM) to capture complaints CMS receives from beneficiaries, providers, or plans about prescription drug plans, pharmacies, subcontractors, and providers. The design of CTM evolved from CMS’ experience with the Medicare-approved prescription drug cards. Because it is a Web-enabled system, it can accept large numbers of daily transactions simultaneously from many users across the Agency. Information can be efficiently exchanged, which allows for quicker resolution and accountability. CMS launched the CTM into production October 3, 2005 and began tracking complaints in January 2006 and we have seen a general decline in the number of complaints during this time.

In addition, in order to assist pharmacists, who have been outstanding in their commitment to service, CMS is working to ensure they have the resources and sup-

port they need. CMS is also coordinating with the States that used their state reimbursement systems to pay for prescriptions that should be paid by the new Medicare prescription drug plans. We are also monitoring plan activities and will use our enforcement measures, if necessary, to ensure they are adhering to the requirements of participating in the Medicare prescription drug program. The 2007 Call Letter outlines CMS plan sponsor evaluation criteria. These efforts build on the preparations that were made long before the January 1, 2006 launch of the Medicare prescription drug benefit. In addition, the 2007 Call Letter contains policy statements developed in response to lessons learned during the Part D program implementation. It also features reiteration of existing program requirements to emphasize their importance to CMS and to our beneficiaries.

CMS Applauds and Supports the Outstanding Work of Pharmacists

Pharmacists are the linchpin of the prescription drug benefit and all over the country they have been tremendous in implementing the new program. Traditionally, the start of a new year is one of the busiest times for pharmacists with new enrollments occurring in commercial and government plans in January. With the launch of the new Medicare prescription drug benefit, the task facing pharmacists was an additional challenge and CMS applauds and supports their tremendous efforts. Pharmacists are working hard to meet the demands of the new program, and CMS will continue to provide them and their software vendors and support associations with the tools they need to serve their customers.

CMS Provides Dedicated Support to Pharmacists

CMS has provided a number of ways for pharmacists to obtain help in filling prescriptions for plan enrollees. To help pharmacists identify what plan a beneficiary is in, CMS collaborated with pharmacists starting in 2004 to create an electronic eligibility and enrollment query system that operates as part of their existing computer systems. If the enrollee does not have a card or proof of enrollment in a prescription drug plan, pharmacists can use this eligibility system (the E1 system) to obtain information needed to fill the prescription. Using instructions and updates provided by their software vendors, retail pharmacists now generally have the ability to perform real-time eligibility determinations on their existing computer systems. Pharmacists can also call plans directly, on lines dedicated for pharmacists. They can contact Medicare's own CSRs on the toll-free pharmacy support phone lines if need be, and CMS also has specially trained case workers in our regional offices who can intervene in special cases to make sure that enrollees get the medications they need.

To help resolve issues pharmacists encounter in dispensing medications to those newly enrolled in the Medicare prescription drug plans, CMS has increased its call handling capacity at the pharmacist help line. In addition, the line is now available 24 hours a day. This increased capacity has reduced the wait time to less than a minute for pharmacists who want to use this mode of communication for eligibility and enrollment determination.

CMS Supports Simplification Initiatives

We have heard concerns from pharmacists about different claims processing and administrative systems used by the various Medicare prescription drug plans. We have helped make sure that plans are aware of the challenges posed by their varying requirements. We have supported external discussion efforts between plan and pharmacy representatives to make rapid technical progress towards more standardized electronic responses and prior authorization process for the pharmacists. CMS remains supportive of this initiative undertaken by the plans and pharmacists to improve how the new program operates on a day-to-day basis. This is one of many examples of how various parties are working together to improve the systems associated with the new program.

CMS has also identified a number of business process issues that can be simplified for plans, physicians and beneficiaries. To supplement established prescription drug reject codes, America's Health Insurance Plans (AHIP), the National Association of Chain Drug Stores (NACDS), the National Community Pharmacists Association (NCPA), and others have announced standardized coding messaging designed to assist pharmacists and better serve beneficiaries when they fill prescriptions at pharmacies. Specifically, these standardized electronic messages will help pharmacists quickly determine the appropriate course of action for filling beneficiaries' prescriptions under four different circumstances: (1) when a particular drug is not covered; (2) when prior authorization is required; (3) when plan quantity or other coverage limitations have been exceeded; and (4) when the pharmacy is not part of the Part D plan's network.

This consensus agreement on new message coding protocols will make transaction processing more streamlined and efficient which will save time and prevent phone calls and delays between plans and pharmacists. This is important not only for the Medicare drug program, but may produce benefits throughout our entire health care system, as these and other protocols are applied to other public and private programs. CMS now views these consistent messages as best practices for the drug benefit, and we expect all Part D plan sponsors to adopt and implement these practices as soon as possible. We will be looking at these and other best practices as measures of plan performance.

To further the goal of simplifying procedures in the new drug benefit, last week the American Medical Association (AMA) and America's Health Insurance Plans (AHIP), in conjunction with CMS, released a standardized exceptions form designed to assist physicians in requesting exceptions and prior authorizations on behalf of Medicare beneficiaries enrolled in Medicare drug plans. This form allows for a simplified process for physicians to apply for coverage determinations on behalf of all of their Medicare patients, regardless of which Part D plan the beneficiary is enrolled in.

In addition to the new messaging standards, we sent information to the plans which will expedite their processes for making sure they are not inappropriately paying for drugs that should be covered under Part B, and we have worked with Epocrates, an electronic prescribing software company, to ensure that their product provides accurate and easy access to plan formularies. We've also held weekly prescribers' conference calls and bi-weekly meetings with the AMA and other organizations to find out what prescribers are experiencing, to supply them with information on our activities and answer their specific questions.

CMS issued a fact sheet on February 24, 2006 to provide physicians with updated, practical information about the exceptions and appeals processes. This fact sheet describes the physician's role in these processes and emphasizes the short decision-making timeframes. In addition, on March 24, 2006, CMS held a "Coverage and Appeals" training session for providers and other CMS partners. We had close to 1,500 sites calling in for the training, and we conservatively estimate that 3,000 people were listening in.

CMS Facilitates Creation of the Pharmacy Quality Alliance

CMS continues to engage in rigorous outreach to the pharmacy community, through national, state and local pharmacy organizations and their newsletters and email lists, as well as their standards organization and technical societies.

I am very pleased to announce the establishment of the Pharmacy Quality Alliance (PQA). Similar to the Ambulatory Quality Alliance (AQA), the mission of the Pharmacy Quality Alliance is to improve health care quality and patient safety, and to reduce overall healthcare costs. The PQA will use a collaborative process in which key stakeholders agree on a strategy for measuring performance at the pharmacy level; collecting data in the least burdensome way; and reporting meaningful information to consumers, plans, providers, and other stakeholders to inform choices and improve health outcomes.

The Alliance highlights the role of the pharmacist as a member of the integrated health care team and recognizes the value the pharmacist can bring to the equation of total patient care. CMS may further support this collaborative process by developing a demonstration project to provide further evidence on the impact of Medication Therapy Management (MTM) and other pharmacist interventions that could help promote high quality patient care and lower costs in both the Medicare and Medicaid programs—a win-win for plans, pharmacists, and most importantly, beneficiaries.

Individuals with more than one chronic disease often require treatment with several prescription medications, which increases their risk for drug-related problems. Additionally, they represent a disproportionate amount of health care expenditures. Each Part D sponsor must have an MTM program for beneficiaries who have multiple chronic diseases and are taking multiple Part D drugs with projected annual costs of at least \$4,000. The quality of care for these individuals can be improved and medical costs can be reduced through MTM, which promotes appropriate medication use, reduces the risk of adverse events, and optimizes therapeutic outcomes.

MTM programs may be furnished by a pharmacist or other qualified provider and must be developed in cooperation with pharmacists and physicians. This creates opportunities for the pharmacists to play active roles in the MTM services provided. To realize the full potential of MTM, quality metrics for MTM and related pharmacy services must be developed so that more can be done to support high-quality pharmacy care.

Physician Outreach Provides Information about Formularies, Exceptions, Appeals, and Expedited Requests

Physicians are a key partner in the implementation of the Medicare prescription drug benefit, and CMS conducted extensive outreach about formularies, exceptions, appeals, and expedited requests to promote effective interactions with physicians and beneficiaries. CMS used the Physicians Regulatory Issues Team (PRIT) web site to provide advice for providers and an invitation for them to call or email CMS with issues or concerns about the Medicare prescription drug benefit. In addition, CMS sent a letter to physicians outlining specific sources of help and information. Some specific steps we have taken to ease processes for both physicians and pharmacists include the following:

- A web-based formulary finder linked to all plan formularies.
- Information about Epocrates, an electronic handheld and web-based drug and formulary reference for physicians, that is providing plan formulary information including both tier and step therapy information and is updated constantly.
- An exceptions and appeals contact list for each prescription drug plan so physicians can help a patient by filing an exception or appeal for a medication or a medication's tier.
- Information about coverage determinations, exceptions, appeals, and expedited requests.
- AHIP, AMA and others developed a standardized form that physicians can use to request prior authorization and coverage for non-formulary drugs.
- To facilitate communications between pharmacists and physicians, we posted a form for pharmacists to use to inform physicians that their patient's plan is requiring use of another drug, step therapy, or prior authorization.
- We have encouraged plans to accept prior approval requests by fax, rather than requiring phone calls from physicians, since that is less time consuming for the physicians.
- A chart and other support tools to determine quickly if the drug a physician prescribed is a Part B or Part D drug.
- Information about the CMS web-based email and weekly conference calls where physicians can get direct help with their concerns.

Strong Enrollment Trends Continue

As a result of successful outreach efforts, participation in the drug benefit is off to a strong start. CMS has exceeded the enrollment target and over 30 million beneficiaries have drug coverage from Part D or a former employer. The number of Medicare beneficiaries receiving coverage continues to grow at a rate of hundreds of thousands of beneficiaries per week. As shown in Figure 2,

Overall prescription drug coverage figures as of April 18 are:

- **Stand-Alone Prescription Drug Plans (PDPs):** 8.1 million people with Medicare have enrolled in stand-alone prescription drug plans. This total includes 1 million beneficiaries who had their enrollment facilitated by CMS. This subset of beneficiaries were either automatically approved for the low income subsidy or applied for the subsidy through the Social Security Administration or states, but had not selected a prescription drug plan on their own.
- **Medicare Advantage with Prescription Drugs (MA-PDs):** Nearly 5.8 million beneficiaries receive coverage through Medicare Advantage plans with drug coverage (MA-PDs). More than 950,000 MA-PD beneficiaries have signed up on their own since prescription drug coverage was added to Medicare Advantage plans.
- **Medicare/Medicaid:** About 5.8 million beneficiaries were automatically enrolled in prescription drug plans, plus about 500,000 enrolled in Medicare Advantage plans with prescription drug coverage.
- **Retiree Coverage:** More than 6.8 million retirees are enrolled in an employer or union sponsored plan that has applied for the Medicare retiree drug subsidy. In addition, about 1.4 million retirees are in employer- and union-sponsored coverage that incorporates Medicare group drug coverage.
- **Federal retiree coverage:** 3.5 million
 - **TRICARE:** There are 1.9 million beneficiaries with TRICARE retiree coverage.
 - **FEHB:** There are 1.6 million beneficiaries with FEHB retiree coverage. This figure includes spouses with Medicare who are covered under a FEHB family policy by retirees who also have Medicare coverage.

• **Additional Sources of Prescription Drug Coverage for Medicare Beneficiaries:**

Approximately 5.8 million Medicare beneficiaries have alternative sources of “creditable” prescription drug coverage:

- **Veterans Affairs (VA):** There are an estimated 3.2 million beneficiaries with creditable drug coverage through the VA.
- **Indian Health Service (IHS):** There are an estimated 0.1 million beneficiaries with creditable drug coverage through the IHS.
- **Active Workers with Medicare Secondary Payer:** There are an estimated 2.0 million beneficiaries who are active workers with creditable drug coverage through an employer group health plan.
- **Other Retiree Coverage:** An estimated 500,000 retirees are continuing in coverage from a former employer or union that supplements individual market Medicare drug coverage or is not coordinated with Medicare drug coverage.

So, in addition to over eight million beneficiaries in stand-alone prescription drug plans, many millions more are getting more comprehensive coverage in Medicare Advantage plans, and millions more continue to receive retiree coverage—exactly as the law was intended to work.

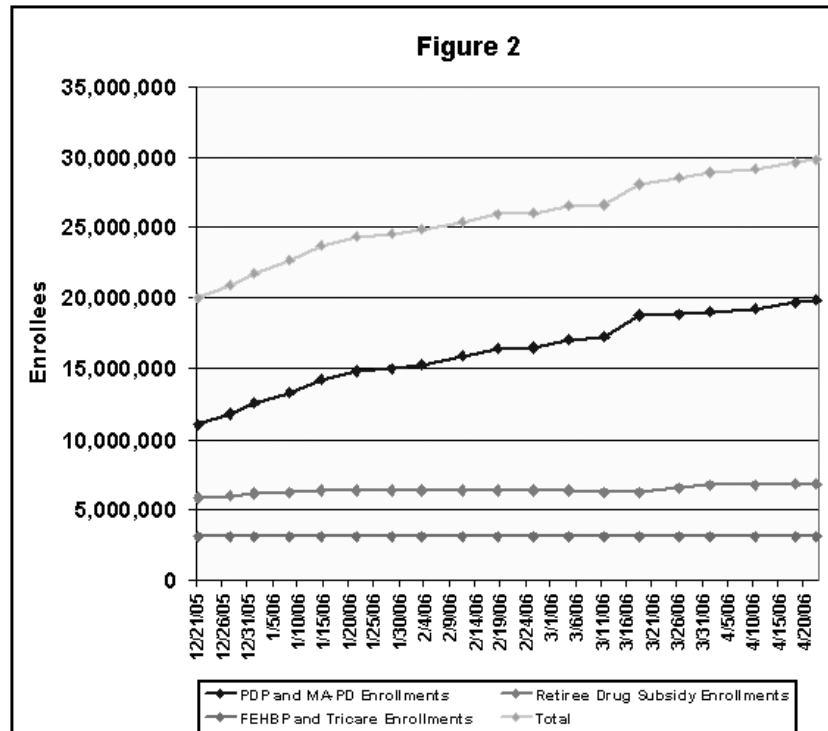


Figure 2: Enrollment in Medicare Prescription Drug Benefit, Medicare Advantage-PDPs, the Retiree Drug Subsidy, FEHBP, and TRICARE^{3, 4}

In addition to general participation, CMS research indicates that our partners’ and our outreach efforts have been particularly successful in minority communities. Seventy percent of Medicare-eligible African Americans, 75 percent of Asians, and

³MA-PDP enrollments are under-reported as plans update CMS records concerning the movement of beneficiaries from MA to MA-PD plans.

⁴Retiree Drug Subsidy enrollment numbers between 12/27/05 and 1/8/06 are estimates.

70 percent of Hispanics have enrolled in Part D or have coverage from an employer taking the retiree drug subsidy. These figures exclude FEHB and TRICARE.

Polls show that people are finding the enrollment process easy and are saving money from participating in the benefit. An AARP survey found that 78 percent of those enrolled in a Medicare prescription drug plan say they are satisfied.⁵ **An AHIP survey released on March 13, 2006 found that** nine out of 10 seniors who are dually eligible for Medicare and Medicaid say they have experienced no problems using the new Medicare drug benefit.⁶ According to AARP's survey, of those surveyed who had prescription drug coverage before 2006, 63 percent indicated that their Medicare drug plan is either better or as good as their previous coverage. Further, the survey found that 40 percent of survey participants thought if Medicare had not added the new prescription drug benefit, they would need to give up things such as groceries, full dosages of medication, or cut back on savings.

More than 30 million Medicare beneficiaries now have prescription drug coverage and CMS is encouraged by the strong enrollment numbers. Outreach efforts will continue to promote enrollment for those who have not yet enrolled.

Competition Helps Lower Drug Prices

Competition in the prescription drug marketplace and among sponsors of Medicare prescription drug plans have helped reduce prescription drug costs for Medicare beneficiaries, which a number of recent studies have illustrated.

CMS analyses demonstrate that Medicare beneficiaries with common chronic conditions can save a substantial amount on their drug bills by enrolling in a Medicare prescription drug plan (PDP) compared to what they would pay with no drug coverage.⁷ For instance, people with Medicare who select the lowest-cost plan in their area may find savings up to 71 percent off the prices they would pay without prescription drug coverage. The analysis also demonstrates that a range of plans available to beneficiaries can provide significant savings. This is also true for a very broad range of plans if beneficiaries are willing to use generic versions of their existing drugs, when available, which are required to have the same active ingredients and work in the same way as the brand-name drug. These results indicate that beneficiaries can see substantial savings on their drug bills by focusing on a few plans with the features they prefer—such as a low premium, or fixed copayments, or coverage in the gap, and low out-of-pocket costs.

Even larger savings are possible—as much as 83 percent—by switching to drugs in the same class that treat the same condition as a beneficiary's current brand-name drug, for example drugs that treat common conditions like stomach acid problems, allergic rhinitis, high blood pressure, and high cholesterol levels. According to Consumers Union, considering these alternative drugs could save beneficiaries billions more in drug costs each year.⁸ Beneficiaries can get personalized information on these additional savings from www.medicare.gov, 1-800-MEDICARE, and many of Medicare's partners.

A number of external reports strongly support these findings. For example, the Pharmaceutical Care Management Association (PCMA) released a study in February 2006 indicating that Medicare drug plans offer significant price discounts compared to what beneficiaries would pay without coverage.⁹ The study found that prices under the Medicare prescription drug program were on average 35 percent less at participating retail pharmacies and 46 percent less through mail order pharmacies. Further, for 25 commonly used medications, the PCMA study found savings from 18 percent on brand name drugs at retail pharmacies to 26 percent at mail order pharmacies. In addition, a January 2006 report prepared by the Lewin Group demonstrates that beneficiaries with chronic conditions, particularly those with multiple conditions, will see significant savings on their prescription drug bills by enrolling in a Medicare prescription drug plan.¹⁰ For example, while beneficiaries with one chronic condition will save on average \$396 on their medications with Medicare drug coverage, accounting for 26 percent of their current drug spending, those with

⁵“New Medicare Drug Benefit is Meeting or Exceeding Expectations,” AARP, Released April 12, 2006.

⁶“Tracking Survey of Seniors Who Are Enrolled in the Medicare Prescription Drug Benefit,” AHIP, Released March 13, 2006.

⁷CMS Office of Policy, Analysis of Savings Available Under Medicare Prescription Drug Plans, March 1, 2006.

⁸“Helping Medicare Beneficiaries Lower Their Out-of-Pocket Costs Under the New Prescription Drug Benefit,” Consumer's Union, December 14, 2005.

⁹“Medicare Drug Discounts Real & Holding Steady,” Pharmaceutical Care Management Association, February 7, 2006.

¹⁰The Lewin Group, “Savings From the Medicare Drug Benefit for Beneficiaries with Chronic Conditions,” Prepared for National Health Council, January, 2006.

four or more conditions will save an average of \$1,774, or 41 percent, on their medications. These studies have made “apples to apples” comparisons of drug prices available at retail pharmacies instead of, for example, common, but misleading, comparisons between retail pharmacy and mail-order prices. In addition, in their recent forecast of prescription drug spending trends, the independent Medicare actuaries have concluded that overall drug spending in the presence of the Medicare drug benefit will be slightly lower when compared to spending in the absence of a Medicare drug benefit, even though Medicare beneficiaries will be able to fill millions more prescriptions than would have been possible without the drug coverage.

Beneficiary premiums are expected to average \$25 a month—down from the \$37 projected in last July’s budget estimates—and the overall cost to taxpayers for 2006 has dropped about 20 percent since the July 2005 estimate, according to the CMS Office of the Actuary. The savings result from lower than expected costs per beneficiary; projected enrollment in the drug benefit has not changed significantly. For the 10-year period from 2006–2015, the net total cost of the drug benefit to Medicare is now estimated to be about \$130 billion less—\$797 billion compared to an estimated \$926 billion last year.¹¹ In addition, the state phase-down contributions are now projected to be \$37 billion (about 27 percent) less over the 10-year period.

Market Forces Drive Plan Simplification

In addition to reducing the cost of prescription drugs, market forces are working to simplify the plan offerings, resulting in more attractive alternatives for beneficiaries. For instance, the standard plan design calls for a \$250 annual deductible. However, to increase their number of enrollees, 85 percent of sponsors chose to not include a deductible in their plan design and, in fact, most beneficiaries are selecting plans without a deductible. CMS is continuing to work on ways to display comparable plan information to make it as easy as possible for beneficiaries to review different plan options and make apples-to-apples comparisons between them. We are encouraged by a recent Washington-Post-ABC News poll, indicating that three-quarters of enrollees said the paperwork to sign up for the benefit was easy to complete, and that nearly two-thirds are saving money under the new program.¹²

Medicare and its partners are already making available personalized information on important plan features, and we are working with many outside organizations to enhance the resources available to beneficiaries to help them identify the specific plan or plans that are a good fit based on their own preferences. As individuals have different needs and preferences when it comes to their health-care coverage, presenting plan features in a way that facilitates comparison on the basis of plan attributes and performance indicators will make it easier for beneficiaries to choose the plan with the features that are most important to them.

In our research, we found that the vast majority of the new enrollees in stand-alone drug plans have chosen plans offering a plan design other than the “standard” drug benefit. Many beneficiaries chose coverage with a low or no deductible, fixed copayments for most prescriptions instead of coinsurance, and/or coverage in the coverage gap—coverage options made possible by the strong competition in the Medicare drug benefit. In fact, as Figure 3 shows, CMS found that nearly 69 percent of PDP and almost 90 percent of MA–PD enrollees chose a plan with no Part D deductible. A very small percentage (2 percent) of PDP enrollees selected plans with a deductible between \$1 and \$249, and 29 percent of the enrollment was in plans with a \$250 deductible.

¹¹ CMS Office of the Actuary, February 9, 2006. Actual future costs of the benefit could be higher or lower than these updated estimates.

¹² Washington Post, April 12, 2006.

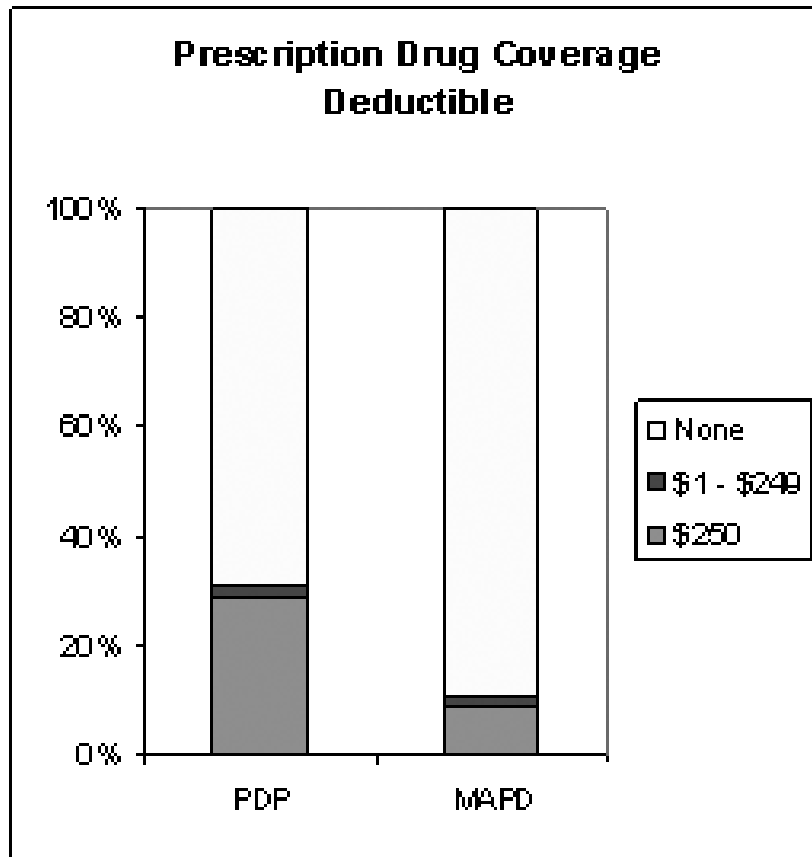
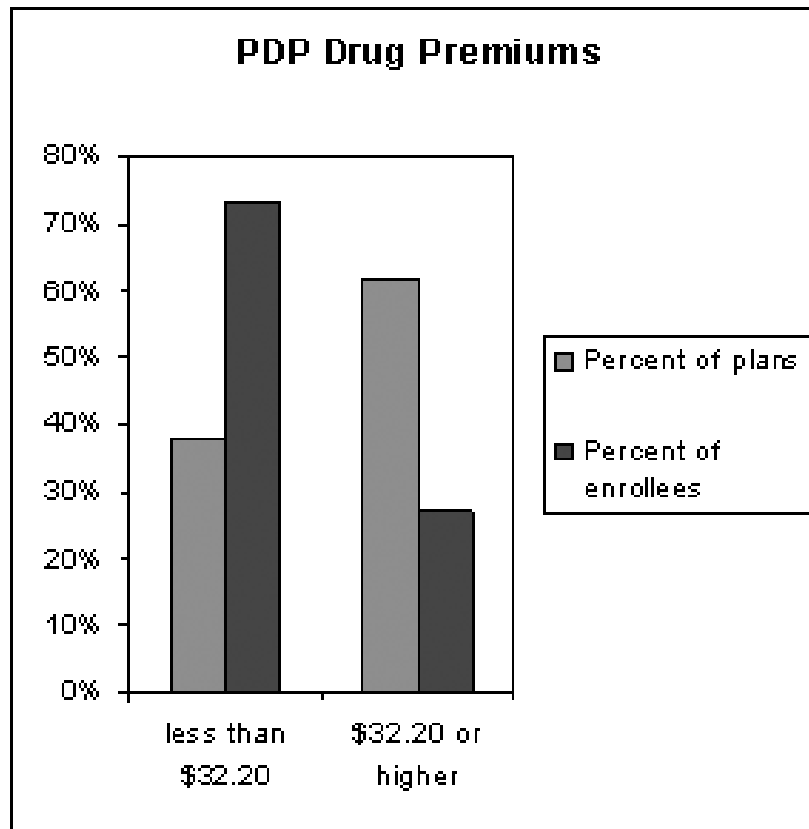


Figure 3: Percent of Enrollment by Deductible Amount

The range of premiums offered by PDPs varies between \$1.87 and \$104.89, and the Part D portion of the MA-PD total premium ranged from \$0 to \$147.12. The majority of PDP enrollees are in plans with drug premiums below the national average. In fact, as shown in Figure 4, while 38 percent of PDP plans offered premiums below \$32.20, 73 percent of the beneficiaries enrolled in one of these plans. It appears that beneficiaries place a high priority on premium when selecting a plan.



Note 1: \$32.20 is the 2006 National Average Premium.

Note 2: This is after excluding the full-benefit dual eligible beneficiaries.

Figure 4: Percent of Plans and Enrollees by Premium

CMS Automatically Enrolled Full Benefit Dual Eligible Individuals into Plans

To prevent a lapse in prescription drug coverage for full benefit dual eligible individuals, CMS worked diligently to make sure they were enrolled in a Medicare prescription drug plan before January 1, 2006. In November 2005, any individual who was a full benefit dual eligible for even one month, beginning in March 2005, was automatically enrolled in a prescription drug plan. While other individuals generally have the opportunity to change plans only at the end of the calendar year, dual eligible individuals have the opportunity to change plans once a month. This flexibility allows them further opportunities to select a plan that best meets their needs.

CMS has also worked with the States to identify and auto-enroll individuals who are about to become full-benefit dual eligible prior to the end of their Medicaid drug coverage to work toward a seamless transition. This includes those Medicaid individuals who will age into Medicare or who will reach the end of the 24-month Medicare disability waiting period. In anticipation of the shift of drug coverage from Medicaid to Medicare for full benefit dual eligible individuals, CMS developed a process for a back-up plan at the pharmacy point-of-sale to ensure that these individuals experience no gap in coverage.

CMS Facilitates Enrollment for Individuals who Qualify for the LIS

To make sure beneficiaries who qualify for the low-income subsidy do not miss out on the coverage, we also facilitated enrollment in a drug plan for beneficiaries who are LIS-enrolled but did not choose a plan on their own. The group includes

not only people who have applied for and been approved for extra help but also people who are enrolled in other federal assistance programs such as Supplemental Security Income and Medicare Savings Programs. This way, we ensured that they do not miss out on comprehensive, low-cost drug coverage.

In the first phase of this effort, CMS began mailing letters to approximately 1 million people who are LIS-enrolled but have not chosen a plan. The letters let them know which Medicare prescription drug plan they would be enrolled in if they took no action before April 30th and that their prescription drug coverage would begin on May 1st.

The letter explains that beneficiaries can choose a different approved plan in their area. It listed all the prescription drug plans available in their region with premiums at or below the low-income premium subsidy amount. It also makes clear that they can decline enrollment if they choose and recommends calling 1-800-MEDICARE to find out more about these plans.

Medicare beneficiaries who qualify after May 15th for the LIS will have a one-time opportunity, using a special enrollment period, to enroll in the drug benefit if they have not already done so. The extra help allows for comprehensive and valuable drug coverage—in most cases it means beneficiaries must pay just a few dollars for every prescription—and we want to make sure that people who need help the most can use this coverage as soon as they become eligible. The change in status resulting from an LIS determination after May 15th is an “exceptional circumstance” that warrants a special enrollment period. This special enrollment period enables these beneficiaries to enroll in a Medicare prescription drug plan right after they become eligible for the LIS. Medicare will also continue to facilitate enrollment into a drug plan for people who qualify for the LIS if they do not choose a plan on their own. Medicare similarly offers one-time special enrollment periods for other important changes in status.

CMS Worked to Achieve a Smooth Transition in Long Term Care Facilities

CMS is committed to ensuring that the estimated 1.6 million people with Medicare in the 15,800 long term care (LTC) facilities nation-wide continue to receive the medications and pharmacy services they need under the new Medicare prescription drug coverage without interruption. Many “private pay” patients in LTC facilities are getting many thousands of dollars worth of help with their drug costs for the first time ever. A majority of individuals in LTC facilities are Medicare beneficiaries, and many of them also are eligible for Medicaid. Individuals in LTC facilities represent a unique and vulnerable population because many have cognitive and/or functional impairments. This population typically has multiple co-morbidities, the highest utilization of drugs, with an average of nine medications per day, and the highest spending for prescription drugs compared to other people with Medicare.

CMS established dedicated fax lines and mail-in services to allow nursing homes to obtain beneficiary enrollment information from CMS. This strategy enabled CMS to help nursing homes identify the plans into which CMS auto-enrolled more than 500,000 residents. Pharmacists used the electronic eligibility and enrollment verification (E1) system to identify the remainder of beneficiaries. By notifying plans that their dual eligible enrollees reside in nursing homes, and by assisting LTC facilities in working to correct cases where copay information is not up to date, CMS is ensuring nursing home residents who are full-benefit dual eligible beneficiaries have access to Medicare drug coverage without premiums and copays.

CMS Has Taken Specific Steps to Address Areas Where State Changes are Needed

Under the MMA, coverage for outpatient drugs for full benefit dual eligible beneficiaries shifted from the Medicaid program to Medicare Part D. As a result, state Medicaid programs no longer must pay for high-cost home infusion drugs. Medicare Part D requires coverage of home infusion drugs that are not currently covered under Parts A or B of Medicare. While the Part D benefit does not cover equipment, supplies, and professional services associated with home infusion therapy, it does cover the ingredient costs and dispensing fees associated with infused covered Part D drugs. Medicaid federal financial participation (FFP) is available for medical supplies and services associated with administering the infused drugs. To the extent that Medicaid covers these supplies and services for its non-dual eligible Medicaid population, the State must also cover these for full benefit dual eligibles.

We are committed to making the distinctions between Part D versus Part B coverage as clear as possible. CMS is currently working with providers, states, and the home infusion industry to clarify payment obligations under Medicare for home infusion therapy. In addition to comprehensive guidance issued in 2005, we recently distributed a quick reference chart to plans and pharmacists and posted a MedLearn article on the subject. In March, CMS sent to plans and the State Med-

icaid Directors letters clarifying the roles of the Medicare Part D drug program and State Medicaid programs in providing home infusion drugs and services. The letter clarified CMS access requirements for home infusion drugs, provided information about how home infusion drugs must be provided in usable forms, addressed the need for plans to receive assurances that ancillary services will be provided, and provided a reminder of the time sensitive nature of home infusion therapy.

Further, we recently sent information to the plans which will expedite their processes for making sure they are not inappropriately paying for drugs that should be covered under Part B, and we have worked with Epocrates, an electronic prescribing software company, to ensure that their product provides accurate and easy access to plan formularies. We've also held weekly prescribers' conference calls and bi-weekly meetings with the AMA and numerous specialty societies to find out what prescribers are experiencing, to supply them with information on our activities and answer their specific questions. Finally, on February 13, 2006, we sent letters to medical specialty groups recommending that providers include certain additional information on prescriptions that may help plans and pharmacists differentiate between Part B and D drugs.

CMS Works With States

Since both CMS and the States are responsible for administering benefits for dual eligible individuals, CMS is committed to working with States on an ongoing and collaborative basis. CMS and the States commenced work in August 2004 through a State Issues Workgroup, which included representatives from State Medicaid Agencies, the Social Security Administration, and CMS to assure that States report and CMS knows of every dual eligible beneficiary in the country undergoing the transition from Medicaid to Medicare drug coverage.

CMS also engaged the States in a series of summits, conference calls, and workshops to discuss and address implementation issues associated with the MMA. These gatherings include monthly all-State conference calls; State Pharmacy Assistance Program Workgroup conference calls; and conferences hosted by organizations representing the States. In addition, CMS provided States with beneficiary enrollment information, comparative information about the plans, and targeted educational and outreach materials. Finally, CMS has worked diligently with States to appropriately identify their full benefit dual eligible individuals.

Reimbursing States for Assisting in the Transition Process

Despite extensive planning and preparation, some dual eligible beneficiaries, particularly those who changed plans late in a month, have had difficulty obtaining their prescriptions at the pharmacy. Due to these difficulties, 32 States took action to ensure people received the medicines they needed by activating their state payment systems. We appreciate the States that supported pharmacists who have faced difficulties in serving certain dual eligible beneficiaries. States paid for prescriptions that should have been paid by the new Medicare prescription drug plans, and CMS believes they should be reimbursed for these expenses.

To that end, we have established a demonstration project to reimburse the 50 States and the District of Columbia for costs they incurred by covering drugs that should be covered by the appropriate plan. Under the demonstration, Medicare will reimburse States by reconciling drug payments with prescription drug plans, and by paying any differential between the drug plan reimbursement and Medicaid costs, as well as certain state administrative costs. Forty-five States and the District of Columbia have been accepted into the demonstration program. Of the States accepted into the demonstration program, 12 did not activate their state payment systems and are seeking reimbursement only for administrative costs. In February we notified states that they could apply for reimbursement for the help they provided to beneficiaries during the transition until March 8, with some states receiving extensions until March 31 for costs associated with Part D claims. By the time that deadline occurred, the vast majority of early difficulties had been resolved and states no longer needed to provide emergency back-up.

We are ready to honor our commitment to states. CMS has extended the deadline for states to incur administrative costs related to transition full benefit dual eligible individuals to May 5, 2006. We are currently working through a contractor to process claims, reconcile with plan sponsors, and begin reimbursing states.

CMS is Correcting Data Transmission Issues

Transmitting accurate and timely beneficiary and plan data was paramount in ensuring the prescription drug benefit could be implemented on January 1, 2006. However, despite everyone's best efforts, information sharing between CMS, the States, and the Medicare prescription drug plans has not always been perfect. Although smooth and timely data transfers among Medicare; our drug plans, Medicare Advan-

tage plans, and retiree plans; and 56 States and territories have occurred for most beneficiaries, we have been working intensively to improve these data handoffs.

As an additional safeguard in mid-January, CMS contracted with Electronic Data Systems (EDS) to help CMS work together with the plans, States, and pharmacies to resolve challenging data translation issues. CMS has worked diligently to ensure our data systems interact properly with other systems so that data information exchanges are accomplished smoothly and completely to correct problems.

Many plans are sending CMS daily files reflecting their enrollment transactions, and reliably use our responses to these daily files as well as our weekly summaries of the results for timely and accurate updates of their systems. Our goal is that plans covering 90 percent of the enrollee population will use these daily and weekly data transfer processes successfully to reduce lags in obtaining updated beneficiary information.

To check and further assure the accuracy of the information exchange between plans and CMS, we have sent special updated data files to plans, including full copayment information, on the full dual and low-income subsidy enrollment in plans. Our goal is to achieve, by ten days before a new coverage month begins, at least a 95 percent match for enrollment and LIS copayment information on applicable beneficiaries between Medicare and the plans. We obtained a match rate of greater than 99 percent for duals submitted by the States in the fall of 2005, and we expect to maintain a high match rate.

CMS is Monitoring Plan Compliance

It is important to note that the plans providing drug coverage to people with Medicare are under contract with CMS. We have the operational responsibility to ensure that the plans are providing the best services available to our beneficiaries. Toward that end, we are enforcing compliance with plan contracts, including call center responsiveness, formulary requirements, appeals processes, and pharmacy contracting.

Key dimensions of customer service include timely access for beneficiaries and their representatives, pharmacists, and other health professionals. HHS is conducting routine surveys to determine plan compliance with Part D standards concerning call abandonment rates and percentage of calls answered within 30 seconds. Plans will receive this analysis to inform their performance and compliance analysis, and information on the performance of plan service lines will be publicly available in the weeks ahead. Complaint rates related to customer service are also an important consideration for future participation by a plan.

We are addressing issues on a case-by-case basis. While we are responding to complaints, we are also monitoring trends. This tracking information can lead to corrective action or sanctions if needed, and will be considered in our contracting decisions for future years. While most plans are complying with the requirements set forth in their contracts, we will use the full array of administrative tools and other enforcement remedies to ensure plans adhere to the terms of their contracts. When we hear of specific complaints we work with plans to ensure timely resolution.

Extensive Plan Formulary Requirements Provide Access to Needed Prescription Drugs

CMS developed a set of checks and oversight activities to ensure that prescription drug plans offer a comprehensive benefit that reflects best practices in the pharmacy industry, as well as current treatment standards. Plan formularies must recognize the special needs of particular types of people with Medicare, such as individuals with mental health issues, individuals with HIV/AIDS, individuals living in nursing homes, people with disabilities, and others who are stabilized on certain drug regimens. CMS reviewed plan formularies and benefit structures to verify that they are in compliance with the following critical requirements: a plan's formulary must cover multiple drugs in each class with a minimum statutory requirement of at least two drugs in each approved category and class (unless only one drug is available for a particular category or class); and CMS requires that each plan's formulary include all or substantially all drugs in each of the following key categories: antidepressants, antipsychotics, anticonvulsants, anticancer drugs, immunosuppressants, and antiretrovirals for treating HIV/AIDS.

In addition, each Medicare prescription drug plan's formulary was developed and reviewed by the plan's pharmacy and therapeutics committee. Each formulary must be consistent with widely used industry best practices. Furthermore, CMS compared the prescription drug plans' use of benefit management tools to the way these tools are used in existing drug plans to ensure they are being applied in a clinically appropriate fashion.

Plans must accommodate the needs of long-term care residents within their formulary structure by providing coverage for all medically necessary Part D medications at all levels of care. Coverage of all medically necessary medications may include, but is not limited to, alternative dosage forms such as liquids that can be administered through feeding tubes, intravenous medications, or intramuscular injections.

CMS will review any request for deletion of a drug from a plan's formulary to ensure continued access to a broad range of drugs. Plans cannot remove a drug from their formulary without, among a number of other steps, first obtaining CMS approval and providing a 60-day advance notice to their affected enrollees. As we deem it appropriate, we are working to strengthen formulary protections. On April 26, we changed our policy to better protect Medicare beneficiaries from the sudden loss of coverage for drugs they currently take. Now, plans that change their formularies during the year will exempt beneficiaries who are already receiving the drugs when the change is made. This should provide many beneficiaries with greater peace of mind that their prescription drugs will remain covered throughout the plan year. The enrollment period continues for almost two more weeks and we are encouraging and helping people with Medicare to review their options and select a plan that works best for them.

In addition, CMS developed specific procedures for timely exceptions and appeals to ensure that enrollees receive prompt decisions regarding whether medications are medically necessary and therefore covered by their prescription drug plan. For example, if the enrollee is requesting coverage of a non-formulary drug, the drug may be covered if the prescribing physician determines that all of the drugs on the formulary would not be as effective as the non-formulary drug or would have adverse effects for the enrollee, or both. The plan would review the physician's determination and must make its decision as expeditiously as the enrollee's health condition requires after it receives the request, but no later than 24 hours for an expedited coverage determination or 72 hours for a standard coverage determination. We are collecting information on the use of a plan's appeals and grievance processes to ensure that each plan is complying with the requirements.

CMS is Ensuring Pharmacists Receive Prompt and Accurate Payments from Plans

We have heard from pharmacies about the early problems they faced in receiving payments from the prescription drug plans for the services they provided. While new billing and payment cycles caused cash flow issues at some pharmacies in January, pharmacies now are receiving payments in regular cycles in accordance with their plan contracts. CMS is taking compliance with required contractual payments very seriously. When we hear specific complaints about a plan failing to abide by its contract with a pharmacy, we investigate and hold the plan responsible for complying with its contract. Our investigations to date have found that pharmacists are generally being paid according to their contracts, though some are having other difficulties, such as not connecting the name of the payer with the prescription drug plan or facing challenges in matching claim dates with payment dates, making it difficult to reconcile their financial books. CMS will continue to investigate and track any complaints from pharmacists regarding payments, and will take action if we determine that plans are not following their contractual agreements.

CMS Commitment to Continuous Quality Improvement demonstrated in Annual Adjustments for 2007

On April 3, 2006 CMS issued the 2007 Call Letter, which provides guidance to existing PDP sponsors as well as those that are newly applying to enter the program. I would like to take this opportunity to highlight some of the more significant policies for bidders in 2007.

CMS Anticipates Bids Will More Clearly Reflect Variations that Beneficiaries Prefer

In order to ensure that plan choices offered in 2007 clearly meet beneficiary needs and enable beneficiaries to compare different kinds of plans and confidently choose the coverage that is best for them, CMS intends to negotiate with PDP Sponsors to ensure that each benefit package they submit will provide beneficiaries with a substantially different option. In 2006, we allowed sponsors to offer a wide array of plan designs in addition to the standard benefit designed by the Congress. However, as discussed earlier, an overwhelming majority of beneficiaries are choosing plans that offer benefits other than the standard option as defined in the law. In 2006, almost 90 percent of beneficiaries were not enrolled in the standard benefit design, but rather have enrolled in plans with low or no deductibles, flat payments for covered drugs, and in some cases, coverage in the coverage gap.

Plans will continue to have flexibility to offer people with Medicare benefit designs with these popular features in 2007. However, in general we expect that more

than two bids from a sponsoring organization would not provide meaningful variation, unless one of the bids is an enhanced alternative plan. Further, CMS anticipates that plan sponsors will design new plan options for 2007 in accordance with the enrollment trends in 2006.

CMS Evaluation Criteria

CMS will issue PDP Sponsor contractor renewal notices to those Sponsors we have determined, based on information available to us, continue to be qualified to hold a contract during 2007. CMS reviews each PDP sponsor's compliance with all requirements of the program to determine whether contract renewal is warranted. While many plans are performing well or achieving significant improvements in key areas of beneficiary service and support, CMS considers non-renewal if there has been a substantial failure to comply with program requirements. We pay special attention to key operational areas which impact customer satisfaction and successful delivery of the benefit, including effective data systems, customer and provider service, exceptions and appeals processes and pharmacy support, which are outlined in more detail below.

Effective Data Systems

Determining a beneficiary's correct enrollment status, including copayment status, lies at the heart of ensuring his or her access to the Part D benefit. Because enrollment data are updated much more frequently than previously done in the Medicare+Choice program, and timely and accurate data processing by plans is essential, CMS expects sponsors to develop and maintain information systems that accurately process updated enrollment information at least weekly, following recommended processing procedures to avoid significant delays or inaccuracies in processing enrollments.

Effective Customer Service

CMS expects PDP Sponsors to provide a high and consistent level of access and service for beneficiaries and their representatives, pharmacists, and other health care providers. CMS has updated for 2007 performance standards for certain customer service and provider contact telephone line operations. CMS is conducting routine surveys to determine Sponsor compliance with Part D standards. For the Current and Prospective Enrollee Call Center, CMS provided specific minimum requirements for hours of operation and the content of information available from the call centers to address beneficiary inquiries. As an example, the call center must answer 80 percent of incoming calls within 30 seconds, and the abandonment rate of all incoming calls is not to exceed 5 percent.

For the Pharmacy Technical Help Call Center, Sponsors must operate a toll-free pharmacy technical help call center to respond to inquiries from pharmacies and providers regarding the applicant's Medicare prescription drug benefit. The call center must operate during the entire period during which the sponsor's network pharmacies in their plans' service areas are open, and must meet the same answering and abandonment rates as the beneficiary call centers.

For the Exceptions and Appeals Call Center, Sponsors must operate a toll-free call center to respond to physicians and other providers for information related to exceptions and prior authorizations, as well as beneficiary appeals. The call center must operate during normal business hours and provide a secure voicemail.

Following Transition Guidance

While the new prescription drug plans are required to cover medically necessary prescriptions, CMS required plans to establish an appropriate transition plan for all new enrollees to address situations where a new enrollee's prescribed medications are not on the plan's formulary. The transition policy allows beneficiaries to get a temporary supply of their current drugs while they determine whether a similar on-formulary medicine will work for them. Additionally, CMS recommends that transition plans address unanticipated enrollee transitions when individuals need to change treatment settings due to a change in their level of care. In addition to reviewing Sponsor reports on its transition compliance, CMS is monitoring complaint rates related to transition coverage of drugs.

Avoiding Excessive Burdens in the Exceptions and Appeals Process

CMS expects PDP Sponsors to provide prior authorization and exceptions forms and access to information to make transition procedures straightforward for providers and patients. PDP Sponsors are expected to limit administrative burdens for physicians and other providers by implementing recommended best practices for consistent forms, including steps to obtain formulary exceptions and processes for

providing needed clinical information for processing prior authorization requests for specialized drugs.

Sponsors must also have a “one stop” area on their web site that provides needed information on the procedures, the forms, and the contact information for their prior authorization and exceptions processes.

Maintain and Strengthen Relationships with Pharmacists through Contractual Support and Avoiding Administrative Burdens

PDP Sponsors must comply with the contractual agreements they have made with their participating pharmacies, and CMS is monitoring pharmacists’ complaints about plan compliance with these agreements and other pharmacy requirements of the Medicare program. Sponsors are also expected to follow recommended best practices for consistent coding and secondary message responses when formulary, prior authorization, Part B coverage, or other rejection edits are activated.

CMS Changes Co-Branding Policy in 2007

In addition to the abovementioned policy for 2007, based on feedback from beneficiaries and the health care industry, co-branding names and/or logos of contracted providers may be confusing to enrollees and unintentionally convey a message that they can only use the co-branded provider, rather than all participating providers listed in the plan’s provider or pharmacy directory. Thus, effective with the beginning of CY 2007 marketing (October 1, 2006), PDP sponsors will not be permitted to place co-branding names and/or logos on their member identifications cards.

Anticipating Next Steps

In addition to the actions CMS took to address issues that arose at the start of the new Medicare prescription drug benefit, we are looking ahead to ensure we address any issues facing people with Medicare, caregivers, providers, the plans, and pharmacists in the future. We are anticipating increased enrollment ahead of the end of the open enrollment period in May, and we are continuing to optimize systems to limit problems with coverage at the pharmacy counter on June 1st. In recent weeks, we have been doing all we can with the support of our partners to help people find out about and take advantage of the new coverage if they haven’t made a choice yet. We are drilling down to the census block and neighborhood levels with our partners—including many of you—where we will be continuing our full scale effort on education and enrollment events.

In addition, we will continue to improve data translation among Medicare, the health plans, and States to continue reductions in the number of rejected or delayed transactions. CMS also is monitoring plans’ customer service and hotline wait times, while also providing responsive service through 1-800-MEDICARE. CMS continues to work with the States participating in the reimbursement program to ensure effective use of Medicare coverage by connecting beneficiaries to their new Medicare prescription drug plans and helping pharmacists use Medicare backup systems if necessary. As implementation continues, and more and more beneficiaries select and enroll in a new prescription drug plan, CMS will continue to improve the program and solve problems, guided by the lessons we have learned to date.

Conclusion

Thank you for the opportunity to discuss our progress during the first four months of the Medicare prescription drug benefit. While we are pleased that millions of Medicare prescriptions are being filled every day, we are going to continue working to ensure every person with Medicare can use their coverage smoothly. I am happy to answer any questions you may have.

Chairman JOHNSON OF CONNECTICUT. Ms. Disman, before we proceed we must recess for three votes. So, it will take about 20 minutes. Then we will pick up with your testimony and then questioning to this first panel.

Thank you very much.

[Recess.]

Chairman JOHNSON of CONNECTICUT The hearing will resume. Ms. Disman, if you will proceed.

STATEMENT OF BEATRICE DISMAN, CHAIRMAN, MEDICARE PLANNING AND IMPLEMENTATION TASK FORCE, SOCIAL SECURITY ADMINISTRATION

Ms. DISMAN. Thank you, Madam Chairman and Members of the Subcommittee. On behalf of Commissioner Barnhart, I want to thank you for inviting me to discuss Social Security's efforts to implement the new Medicare Part D low-income subsidy of the Medicare Modernization Act, or MMA.

I am Beatrice Disman, Regional Commissioner of the New York Region of the SSA. I have been in my current position since 1995, and I have actually been with Social Security since 1965, and I was there for the implementation of the Medicare program in our midtown Social Security office.

In December 2003 Commissioner Barnhart asked me to chair Social Security's Medicare Planning and Implementation Task Force, making me responsible for Social Security's role in implementing MMA.

As you know, Madam Chairman, Social Security was given the responsibility from Congress to take "extra help" applications and to make eligibility determinations for individuals who were not automatically eligible. I have explained the eligibility requirements in detail in my written statement.

Social Security was given its MMA responsibilities because of its network of nearly 1,300 offices and 40,000 employees across the country. We are in every community, and that was a real benefit for the program as well as for our role in administering some parts of the Medicare program already.

Upon passage of MMA, we immediately recognized the development of the simplified application for extra help was essential for successful implementation of the program. As I have described in my written statement, we, in partnership with the Centers for Medicare and Medicaid Services, conducted substantial testing of the extra-help application. The paper application changed significantly over time, going through many drafts before being finalized.

Our system staff contributed to the design of the application, to make sure the information on the form could be electronically scanned into our computers, thereby minimizing the number of employees needed to process incoming forms.

We worked to develop alternatives to the traditional paper-based application. In July of last year we unveiled the Internet version of the application, allowing people to file online for help with costs associated with the Medicare drug plan. The online application has been a tremendous success with more than 1,300 individuals daily filing for the extra help.

Telephone inquiries were also part of our efforts to make the extra-help application process as simple as possible. We provided extensive training to our teleservice representatives so that they could answer subsidy-related questions. We developed an automated application-taking system, allowing our teleservice representatives to refer callers directly to specialized claims-taking employees who could take the application by phone.

We developed a computer matching process with the Internal Revenue Service to validate resource and income-related information provided by applicants. Using this computer match allowed So-

cial Security to build an application process that would not require applicants to submit proof of resources and income as long as the applicant's statement was in substantial agreement with the computer records.

This permitted greater use of the scannable and the Internet application, and actually reduced the need of Medicare beneficiaries to travel long distances to visit our Social Security offices.

I would now like to turn to the efforts Social Security has undertaken to inform beneficiaries about the extra help available for prescription drugs. For example, more than 72,000 Medicare outreach events have been held and in many of these, we were certainly there with CMS and CMS was certainly at these events with us.

As we also had targeted application-taking events held in our Social Security field offices, I can tell you from my New York experience that we opened our offices on Saturday and stayed late in the evening to assist people to file for the extra help. We continued to work with all the States and other organizations to identify people with limited income and resources, who may be eligible for the extra help, and to take applications from them. We are on site in senior citizen centers, hospitals, community centers, housing authorities, adults' homes, churches, just to mention a few locations.

Our outreach efforts are continuing because there is no deadline for individuals to file for the extra help for lower-income beneficiaries. Although the new prescription drug plan did not begin until January of 2006, Social Security began mailing applications to individuals who might be potentially eligible in May 2005. The initial effort also allowed us to begin making eligibility determinations for the extra help as early as July 2005.

As much as the initial mailing of applications was important, follow-up telephone calls or letters to individuals who didn't return the application was just as important.

Again, there is more detailed information in my statement. The results of these many months of efforts speak for themselves. At the end of April, Social Security has received applications from more than 4.9 million beneficiaries, including almost 850,000 applications that were duplicate applications.

Of the remaining approximately 4 million, we have made determinations on 3.9 million individuals. We have now found that 1.7 million individuals are eligible for the extra help.

In conclusion, I want to express Commissioner Barnhart's thanks and my personal thanks to the Committee for your continuing support for the agency. Your support for the President's 2007 budget will allow Social Security to continue to provide the kind of service your constituents have come to expect from us, not only in administering the low-income subsidy and premium withholding for the Medicare prescription drug program, but also for our traditional services. We look forward to working with you as we continue our efforts to reach the low-income population.

Thank you. I will be glad to answer any questions you may have. Chairman JOHNSON of CONNECTICUT. Thank you very much. [The prepared statement of Ms. Disman follows:]

Prepared Statement of Beatrice Disman, Chairman, Medicare Planning and Implementation Task Force, Social Security Administration

Madam Chairman and Members of the Subcommittee:

On behalf of Commissioner Barnhart I want to thank you for inviting me to discuss Social Security's efforts to implement the new Medicare prescription drug coverage low-income subsidy program.

SSA has already done a great deal to assist low-income Medicare beneficiaries in receiving extra help with their prescription drugs through the new Medicare prescription drug coverage, and we will continue this mission with a firm commitment to the public we serve. As Commissioner Barnhart has said, "Together, we can make sure no one has to make the difficult choice of spending their limited income on prescription drugs or other basic needs."

Background

To begin, it may be helpful to describe Social Security's role and responsibilities regarding the new Medicare prescription drug coverage. This will provide the context to further describe SSA's activities in getting low-income people the extra help intended by Congress.

As you know, the Medicare Modernization Act, or MMA, enacted in December 2003, established the new Medicare prescription drug benefit. The new Medicare prescription drug coverage was designed to allow all people with Medicare an opportunity to voluntarily enroll in prescription drug coverage. MMA also provided an extra level of assistance for people with Medicare who have limited incomes and resources in helping to pay for the monthly premiums and cost-sharing that is required by the new Medicare prescription drug coverage. This assistance is the low-income subsidy, or "extra help," as it is frequently called.

The responsibility for enrolling individuals for the prescription drug coverage is a joint effort between the Department of Health and Human Services (HHS) and private insurance companies, which establish Prescription Drug Plans (PDPs) for that purpose. Individuals who were already eligible for Medicare and full Medicaid benefits were automatically enrolled by the Department of Health and Human Services in the subsidy, and did not need to apply. They were also auto-enrolled in a plan in November 2005.

SSA was given the responsibility by Congress to take extra help applications and to make eligibility determinations for individuals who were not automatically eligible. In order to be eligible for the subsidy, individuals must have incomes below 150 percent of the poverty level applicable to their corresponding household size, and resources of less than \$11,500 for single individuals or \$23,000 for married couples.

Individuals with incomes between 135 percent and 150 percent of poverty are eligible for a subsidy amount based on a sliding scale. Individuals with incomes below 135 percent would be eligible to receive the most subsidies.

Additionally, SSA was charged by Congress with the collection of premiums for the prescription drug program itself, in cases where beneficiaries tell the Prescription Drug Plans when they enroll that they want their premiums withheld from monthly Social Security benefits. This withholding of premiums is similar to the function SSA already performs for beneficiaries in the withholding of other Medicare premiums. SSA was given these responsibilities because of its network of nearly 1,300 offices with 35,000 employees across the country, and because of its already existing role in administering some parts of the Medicare program. Over the past 70 years, SSA has gained a reputation for helping citizens in the communities where they live, and Congress realized that SSA's presence "on the ground" would be vital in the launch of the Medicare extra help program. Also, the low-income subsidy was designed with many similarities to the Supplemental Security Income (SSI) program, a means-tested assistance program for low-income aged, blind and disabled individuals, which SSA has administered for more than 30 years.

Obviously, these new responsibilities have impacted SSA's workloads. We saw significant increases in our office visits and telephone calls, especially in December and January. Some of this increase was due to uncertainties by Medicare beneficiaries on whether to contact CMS, the Prescription Drug Plans, or SSA to enroll in Part D. However, the increases were also caused by changes that SSA implemented to its enumeration process in mid-December. The strengthened evidence requirements for obtaining a Social Security card have caused a sustained increase in our field office traffic.

Development of Extra Help Application

Upon passage of MMA, Social Security immediately began planning for the implementation of the limited-income subsidy. We recognized from the onset that development of a simplified application for the extra help was essential for successful implementation. Thus, our goals were to develop an application that elderly and disabled Medicare beneficiaries, their caregivers, or other third party assistance providers would be able to understand and easily complete. SSA also wanted to maximize the use of automation, not only to process these forms efficiently, but also to process them in a timely manner.

To accomplish these goals, SSA conducted substantial testing of the extra help application form. The paper application changed significantly over time, going through many drafts before being finalized. Social Security, in collaboration with CMS, conducted focus groups with current Medicare beneficiaries to test potential applicants' understanding of the application, and conducted special cognitive testing of the subsidy application and had design engineers review the layout of the applications. We also discussed various draft versions of the application with national and local advocacy groups and with State Medicaid Directors.

Our Office of Systems staff contributed to the design of the application as well to make sure that the information on the form could be electronically scanned into our computers, thereby minimizing the number of employees needed to process incoming forms.

Realizing the need to reach our beneficiaries in new ways, SSA worked to develop alternatives to the traditional paper-based application. In July of last year, we unveiled the Internet version of the application located at www.socialsecurity.gov, allowing people to apply online for help with Medicare Prescription Drug Plan costs. The online application has been a tremendous success, receiving one of the highest scores ever given to a public or private sector organization by the American Customer Satisfaction Index (ACSI). As of April 2006, we are still receiving more than 1,300 Internet applications daily.

Telephone inquiries were also part of our efforts to make the extra help application process as simple as possible. We provided extensive training to assist our teleservice representatives in answering subsidy-related questions. We also developed an automated application-taking system, allowing the teleservice representatives to refer callers directly to specialized claims-taking employees who could then take applications by phone. This new system allows individuals calling our 1-800 number to immediately file for the extra help.

Under authority created by the Medicare Modernization Act, we also developed a computer matching process with the Internal Revenue Service (IRS) regarding the validation of certain income information provided by applicants. Using this computer match allowed SSA to build an application process that would not require applicants to submit proof of resources and income, as long as the applicant's statement on the application was in substantial agreement with the computer records.

In summary, although means-testing is by its very nature complex, we believe that we have created a simple application process, which allows individuals to apply for the extra help as quickly and easily as possible, while also taking advantage of current technology.

Outreach Efforts

I would now like to turn to the efforts SSA has undertaken to inform beneficiaries about the extra help available for prescription drugs. Efforts to educate the public about the new, extra help program began almost immediately after passage of MMA, and this outreach continues today. SSA has worked with CMS and other Federal agencies, community based organizations, advocacy groups, and State entities in order to spread the word about the available extra help.

During the past year, SSA has held more than 72,000 Medicare outreach events. Targeted application-taking events were held in Social Security offices throughout the country, and personal invitations to these events were mailed to beneficiaries who had not yet applied for the extra help, but had been identified as being potentially eligible for the program.

We continue to work with States that have their own pharmaceutical programs, State Health Insurance Programs, Area Agencies on Aging, local housing authorities, community health clinics, PDPs, and others to identify people with limited income and resources who may be eligible for the extra help.

Throughout these efforts, SSA's goal has been to reach every potentially-eligible Medicare beneficiary multiple times, in a variety of ways, for example, by targeted mailings, follow-up phone calls, and targeted events. And while we are confident we have taken appropriate steps to reach out to those who may be eligible for the extra

help, our outreach efforts will continue throughout 2006. There is no enrollment period for the extra help—a Medicare beneficiary can apply at any time.

Additional Outreach & Mailing of Subsidy Applications

Although the new Medicare prescription drug coverage did not begin until January 2006, SSA began mailing applications to individuals who were potentially eligible for extra help in May 2005. During the following three months, we mailed almost 19 million applications. Our goal was to have as many potentially eligible limited income Medicare beneficiaries as possible file for the extra help before the Medicare prescription drug program started in January 2006.

We also intended to cast the widest net possible in our efforts to reach the public. Thus, we sent the 19 million applications to potentially eligible individuals, even though we knew that not all of this group would meet the income and resource requirements. This initial effort also allowed us to begin making eligibility determinations for the extra help as early as July 2005.

As much as the initial mailing of applications was important, follow-up contacts with those individuals who did not return the application was just as important. We contracted with a vendor to remind individuals of the availability of the extra help program and to ask if they needed assistance. Of the 9.1 million people who were called by the vendor, 800,000 had applications resent to them, and 400,000 requested assistance and were referred to SSA. In addition, 5 million follow-up notices were sent because the vendor could not locate a phone number for the individual (for example, an individual who was displaced by Hurricane Katrina).

We continue to use Agency mailings to inform the public. For example, the cost of living adjustment notice sent in December 2005 to 52 million Social Security beneficiaries contained information about the new drug program and the availability of extra help. The 4.2 million letters SSA sent to individuals potentially eligible for extra help, during September and October 2005, also contained information about the subsidy.

Also, SSA identified approximately 1.5 million disability beneficiaries who received an extra help application mailer, but did not file an application. We mailed a follow-up notice to these beneficiaries between March 16 and April 11 notifying the beneficiaries that they may be eligible for the subsidy.

In addition, as a pilot, we recontacted approximately 5,000 beneficiaries, who did not respond to an extra help application mailer, but had previously applied for and received the Medicare \$600 drug discount card credit, to offer help in completing the extra help application. We are now looking at expanding the effort.

SSA is also examining other ways in which we might reach individuals who could be assisted by the extra help program. For example, we established cooperative projects with tax preparers, who deal with people filing for the Earned Income Tax Credit, to screen for the extra help.

Success So Far

As of April 30, SSA has received applications from more than 4.9 million beneficiaries, of which almost 850,000 were unnecessary, because either the applicants were automatically eligible or because they had filed more than one application. We have made over 3.9 million determinations on the eligibility for extra help and have now found more than 1.7 million of these individuals eligible. We have also notified the individuals who filed unnecessary applications of their current eligibility.

While we are proud of the initial success that we have had with helping so many beneficiaries pay for their prescription drugs, there is much more that we need to do. Commissioner Barnhart has made it clear that we need to continue to aggressively promote this valuable benefit, and to this end, we continue to look for ways to reach those eligible for the extra help program.

While SSA has no direct role in assisting individuals in either selecting or enrolling in PDPs, we have also provided instructions to the field offices on how to make sure those with the new Medicare prescription drug coverage questions are directed to the resources they need. In some cases this means our employees will simply refer the questioner to 1-800-MEDICARE, or to the beneficiary's PDP provider, but in other cases it means making a personal call to state coordinators, reprinting and faxing award notices, and even making emergency calls to CMS Regional Offices.

In short, we are committed to doing whatever we can to help make this new program accessible to our beneficiaries.

Conclusion

In conclusion, I want to express Commissioner Barnhart's thanks, and my personal thanks, to this Committee for your continuing support for the Agency. Your support for the President's 2007 budget will allow Social Security to continue to provide the kind of service your constituents have come to expect from us, not only in

administering the low-income subsidy and premium withholding for the Medicare prescription drug program, but also for our traditional services.

We look forward to a continued dialogue with your Committee as we progress with implementation of the extra help program. We very much want to hear your ideas. While we have found that there is no single contact method that guarantees success, we have learned that the more times we reach these limited-income beneficiaries, the more we are able to help them.

Thank you and I will be glad to answer any questions you may have.

Chairman JOHNSON OF CONNECTICUT. We have now just passed an hour since I convened this hearing. In that hour, 1,813 seniors have joined the Medicare Part D program. In addition, Mr. Stark has asked me to enter into the record the Congressional Budget Office's letter that estimates that 1 million beneficiaries would enroll in Part D in 2006 if the enrollment period were extended.

[The information follows: PENDING]

Chairman JOHNSON OF CONNECTICUT. Dr. McClellan, I understand that your actuaries at CMS have done similar estimates, and I would like you to comment on this estimate and also to provide for the record the statement from the CMS actuary on this issue.

Dr. MCCLELLAN. We will be happy to do that. In terms of the impact on the enrollment deadline, our actuaries have concluded, like actuaries around the country find with insurance plans and other benefits, that deadlines are very important in encouraging people to act.

The CMS actuaries concluded that without the deadline, 1.6 million fewer Medicare beneficiaries would enroll in the drug coverage and get advantages from the benefits. I have been going around the country a lot. I see this firsthand. A lot of the people who are looking in the program now are people who have been putting off a decision. Signing up for health insurance may not be the most fun thing you do in a day, but they know it is very important for their health and very important for their finances so they are doing it. Also a lot of people with low drug costs are understandably waiting until close to the deadline.

I was down in Arlington, Texas and met a nice lady there who said she takes only one or two drugs now, but she will sign up for the coverage now so she will have peace of mind as she gets older. She is 102 years old, but this benefit works for all beneficiaries no matter how old they are.

We are seeing more people sign up because the deadline is there. Now is the time when we have lots of assistance available for them, when all of our partners, all of our customer service representatives are there, between now and May 15, to help them make that decision.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. We look forward to having that letter to put in the record, alongside the other letters. It shows how difficult it is to estimate.

I was interested that The New York Times had said the deadline was a useful prod for fence-sitters. Certainly we all know how much we intend to do something and often don't do it until we absolutely have to do it.

I also thought it was very interesting that 75 percent of seniors who have enrolled in Plan D are either satisfied—are either very satisfied or satisfied with the plans performance.

I was equally interested in, because both of you have worked very hard at getting tools out there, getting local voices in the community, enabling seniors to go to people they trust. Indeed, in one of my senior citizens centers they don't want the choice because they like the pool of people who are so well trained, and they would rather wait their turn with their local advisers. That has worked very, very well.

All of the grassroots training that you have done is very important. Yet in the Kaiser Foundation poll of April 6th to 11th, they found that 54 percent of those who had chosen a Medicare drug did so on their own. That is interesting to me, because in my office we have had people call and say oh, this is so confusing, and this is so confusing. When we ask them have you tried, they say, oh, no. When we have them try or when I see them at sign-up things, they say it isn't so confusing.

So, it is unfortunate that so much print and breadth of public leaders has been devoted to basically scaring seniors that was dangerous and difficult; when it is, it certainly is something you have to put your mind on, but the people you have gotten out there to help one on one have made all the difference; and that many seniors, we forget, many seniors are able to use the computers.

In fact, some of the advisers who signed up, one I met recently, was a former human resources developer. So, we have had some very good success not only with getting seniors to sign up, but with generating support in the community for helping one another. That has been wonderful to see. Frankly, I haven't seen that level of just communities coming together to help each other in a long time. We will come back later on to some other aspects of the plan that will help it.

Right now, I will recognize Mr. STARK.

Mr. STARK. Thank you, Madam Chair. Could I just borrow this? Look at those aluminum tubes, just right out of the State Department testimony.

In your benefit design, as I understand it, about 86 percent of the stand-alone plans have a doughnut hole or some coverage gap, and about 8 million people and change have enrolled in stand-alone plans.

Can you give me an idea, or can you get back to me as to how many of these 8 million in stand-alone plans still have a doughnut hole or some form of coverage gap, or do you know, approximately?

Dr. MCCLELLAN. I can get you that number, approximately, in just a minute. What the beauty of a program with choice is of the options out there, people don't have to choose any one of them that they don't like, and people are disproportionately enrolling in the plans that fill in the doughnut hole, just like they are disproportionately enrolling in plans that provide other benefits. That is a big extra help for people who have high expected drug costs.

Mr. STARK. Okay. Again, my concern is not that we can't help some people, as I said earlier. You throw \$1 trillion at 40 million people, somebody has got to get help besides the pharmaceutical industry.

I have trouble with—and I hate to tell you this, but you probably already know it—your boss, Secretary Leavitt, just some moments ago, in his testimony in the Senate, before the Health and Human Services Appropriations Subcommittee, said, I think definitively as Congress Daily put it, said: There ain't going to be any extension.

I was kind of hoping you guys would have an epiphany, is that what it is, John, in the last—in the eleventh hour, and save a lot of those seniors from the penalty.

If I am correct in this assumption, I know you have stated in a variety of forums and ways that the penalty is necessary, basically to prevent adverse selection, for me to stay out of the plan until I know I am going to need diabetic drugs or chemotherapy and then sign up. That is why I would agree with you and everybody else, and at some point, a penalty, like we have in Part D.

I am not so sure, maybe you could convince me otherwise, that we lose a lot by letting people go to January without a penalty. If what you are suggesting is out of these 7- or 8 million people, that they have got this all figured out, my guess is that with their shoes and socks on, they can do the math; and the penalty would cost them more than what they would spend in 8 months in premiums.

I am sure that is the case in any of these plans; that if you look at some life expectancy beyond 5 years, to say, jeez, I am going to have a penalty of 10, 12 percent, what it could run, for the remainder of my life, or I have the option of paying for just an extra couple of months, even these guys are going to figure out that they are probably on the better side of the math, if they are that sophisticated, to take the lower premium and not gamble. You may have figured it out differently.

If, though, you will agree with me, without a question of fault, that there is some confusion, there is some waiting because of lack of resources to take everybody and get them the information, the costing they need, instantaneously—and I don't expect we could do that. Quantify for me the dollar harm, if you can, that you could see in giving these people another, basically, 7 months, and forgoing that penalty until the first of the year.

You have done it for some already. My guess is that in the long run, we would have people who would have done a better job of selecting the right plan, and the government would lose some penalty dollars, and as CBO tells us, \$2 billion over \$5 billion. If you are talking about a \$1 trillion program, I would submit that that is not very urgent to us, and we may be better off with a better-served population.

Quantify for me, the other side of that, which I know you are on.

Dr. MCCLELLAN. Let me try to throw out a few numbers. First of all, I think you are absolutely right; for someone who is thinking about getting this protection, because the premiums have turned out to be so low—in your district it is only around \$10 a month and all over the country it is under 20—this is a very inexpensive way to get peace of mind for the future.

Now, in terms of the number of people that are affected here, as you mentioned there are about 5- or 6 million who have not yet signed up and who don't have coverage from another source.

Out of that group, more than half are eligible for the low-income subsidy. As we have already talked about, we will be continuing

and redoubling our efforts to reach that population. We have new partnerships that are really getting underway right now. There, we will continue to be getting them enrolled as quickly as we can, before or after May 15. That takes us down to 2- or 3 million beneficiaries, which is well under 10 percent of the total Medicare population. We are seeing hundreds of thousands of people sign up each week. We are seeing a surge in the number of our phone calls that we are getting now, a surge in the use of online enrollment. People clearly are starting to focus in with the deadline. I think we are going to get—have an opportunity to get most of those people enrolled now.

The reason that I think—well, let me give you one more important number to focus on; that is the \$1,100 that is the average savings a beneficiary will get this year from the drug coverage. If you talk about the penalties, the penalties come from beneficiaries not getting this assistance as soon as possible.

If we lose 1.6 million people, which is most of this population that is left—that is actuaries' estimates—that is forgoing billions of dollars in drug savings that our beneficiaries really need. Between now and May 15 is when all of the assistance is available to help them make a good choice and start saving money. That help is not going to be available after May 15.

So, the result is potentially—I think that is the right number—\$1 billion in lost opportunities to save on the drugs. It is not a large part of our overall population. I am not as concerned about the penalty amounts as I am about our beneficiaries getting help with their drug costs, making a confident decision about their coverage as soon as possible.

Mr. STARK. If the Chair would indulge me for just another minute.

CBO tells me we get another 1 million people in. It is dueling statistics, but it is a gamble. My question to you is twofold: One, let us gamble on the side of getting people in. They will be better off for it as you and I would agree.

Secondly—and I am sure Ms. Disman could remind you if you don't know—but there is not a one of us here on this dais who hasn't had a town meeting where somebody has come in and waved this direct-mail solicitation to help them solve a notch problem.

What you may very well be doing for us, and you will earn the enmity of everybody on this dais, is creating a whole new batch of notch babies, who, for the next 10 years, will be coming to our town meetings and saying, why do I have to pay this extra money? I don't think there is anybody here who will disagree with this—you would help us a lot, Doc, if you could find a way to do away with this potential notch.

Dr. MCCLELLAN. I very much appreciate your commitment to helping everyone possible save under the drug benefit. I am sure we will keep talking about this not just now, but soon after May 15 as well.

Chairman JOHNSON OF CONNECTICUT. I would like to recognize now Mr. McCrery, in whose district 73 percent were signed up in the middle of April.

Mr. MCCRERY. Thank you, Madam Chair. I thank both of you for appearing today. I also want to say what a good job CMS and

Social Security and the Department of Health and Human Services (HHS), for that matter, have done since the early rollout of this program.

We all know there were problems with the early rollout, everything from speedy payment, pharmacies, to dual-eligible seniors having problems, some drugs being dropped or not covered. CMS, HHS, jumped on that with both feet, and you haven't let go since. You have just done a fantastic job of admitting that there were problems and getting after them and solving them.

The SSA has done a wonderful job of reaching out to seniors and offering your outreach to seniors all across the Nation and trying to help seniors understand this program and to get help getting signed up for this program.

So, I think, particularly for those of us from Louisiana, it is refreshing to be able to compliment Federal agencies for a change. You certainly deserve it.

Dr. MCCLELLAN. Thank you.

Mr. MCCRERY. Dr. McClellan, you talked about the premiums. I think, originally, weren't premiums projected to be about \$35 or \$37 a month?

Dr. MCCLELLAN. Thirty-seven dollars a month, yes.

Mr. MCCRERY. Thirty-seven dollars a month. Now they are between \$20 and \$25, on average?

Dr. MCCLELLAN. That is right. It is about \$25, on average. Overall, the Medicare Advantage plans have premiums that are significantly lower than that, on average.

Mr. MCCRERY. What do you think accounts for the difference in the original projections and what is reality?

Dr. MCCLELLAN. I think it is two things. First of all, it is the strong competition that we have among the drug plans. They know that they have got to offer strong discounts, low-cost effective coverage, or they are not going to get beneficiaries.

Second, we have seen some very impressive shopping behavior by our beneficiaries. They are overwhelmingly enrolling in plans that are relatively low cost. That is good news for them. They are getting much lower premiums as a result. It is good news for taxpayers because the cost of the benefit is coming way down as a result.

Our Trustees Report, issued this week, pegs the drug benefit cost to be 20 percent lower than had been projected as recently as last year, before these premium bids and before we saw the actual choices that our beneficiaries are making.

Getting back to Congressman Stark's questions, 1 in 4 of our beneficiaries is signing up for a plan that has coverage in the gap. So, the plans are responding, not just with lower costs but also with coverage, more like with what many people want. So, I would give a lot of credit to our beneficiaries making informed choices. It takes some effort, but I would also give a lot of credit to all of our partnerships in networks to help people make an informed choice. That can be as simple as calling 1-800-Medicare or going to one of these thousands of events around the country.

Mr. MCCRERY. So, private sector competition seems to be working after all.

Dr. MCCLELLAN. Private sector competition plus beneficiaries choosing the coverage that they want, not the coverage that others tried to design for them.

Mr. MCCRERY. Are you familiar with the recent survey from the pharmacy benefit managers trade group, Pharmaceutical Care Management Association, in which they track the top 25 drugs purchased by seniors and show the costs at retail pharmacies and under the program and through mail order programs?

Dr. MCCLELLAN. Yes, I think I have seen that, sir.

Mr. MCCRERY. They show discounts of 35 percent to seniors at retail pharmacies—seniors who are in the Part D program—and 46 percent through mail order. A lot of seniors can do mail order because they have maintenance drugs that they know they will need every month so they can do it through mail order. Sometimes they have to go to retail pharmacies, but a lot of them can get it through mail order. So, that is a big savings that they can get through mail order.

However, CMS, I understand, for those that signed up for the lowest-cost plans, they can get discounts of 57 percent to 71 percent in those low-cost plans. That is a huge savings for seniors. I think you earlier stated that the average savings per senior who signed up for Part D is \$1,100; is that right?

Dr. MCCLELLAN. That is right, it is 50 percent.

Mr. MCCRERY. It is about \$100 a month these seniors are saving. That is just the average.

Dr. MCCLELLAN. One other way to look at it, if you don't mind, is our actuaries in February issued their projections for national health expenditures. For 2006, the first year we have full implementation of the drug benefits, their estimates of total prescription drug spending in the United States have come down significantly because of exactly what you mentioned: the substantially lower prices that seniors are now getting on their drugs.

Even though seniors are getting millions more prescriptions filled because of the coverage, it also brings down the cost of drugs, so it is many more prescriptions, but less total spending on prescription drugs in this country as a whole this year, because of the drug benefit.

Mr. MCCRERY. What is happening—I will see if you agree with me—but what is happening is seniors are now in pharmaceutical plans, drug plans, that are like the one I had through the Federal Employees Benefit Plan.

I was paying less for my drugs than I would have paid had I not had a plan and just walked down to the corner drugstore and paid retail for it, because I got a discount through my health plan. Now we are giving seniors a discount through their health plan, Medicare, through Part D. That is what is happening.

Now, my time is out, but I hope somebody will talk about the low-income seniors and how we are taking some of the burden off the States, who were previously paying the cost for those seniors, and how if the States want to, they can supplement Part D and actually make those seniors whole or even better off than they were.

Dr. MCCLELLAN. Many of them are.

Mr. MCCRERY. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Now I would like to recognize Mr. John Lewis of Georgia who has about 69 percent of his seniors—sorry, 69 percent of the seniors in his district signed up. Mr. Lewis.

Mr. LEWIS. Thank you very much, Madam Chair.

Dr. McClellan, in your response to the question raised by my colleague from Louisiana, are these the same actuaries who said that this plan was going to cost about \$400? Are they using the same people?

Dr. MCCLELLAN. Those are the same people. That was the April estimate from 2004 to 2013. We are now looking at 2006 to 2015 and the cost projections are right in line with what the actuaries had forecast back then.

Mr. LEWIS. You are really telling us that these wonderful, unbelievably qualified people hit the dime on the head?

Dr. MCCLELLAN. Very close to their original estimates. Back in February, when the President's budget came out, our actuaries compared a comparison.

The trillion dollars I think that Congressman Stark—I am not sure where he got that from. I am sure he can explain more clearly than I. Some estimates are of the so-called gross costs of the benefits that do not count the savings from premiums, that do not count the savings from State payments for a portion of the costs that they would have incurred, that do not count all the savings in Medicaid.

If you look at the net cost of the Federal Government, as our actuaries did in that comparison in February, which we would be delighted to share with you, they are roughly in line with what had been forecast a couple years ago.

Mr. LEWIS. Doctor, let me ask you, have you seen the GAO report that was released today?

Dr. MCCLELLAN. I have.

Mr. LEWIS. Do you care to comment on the report?

Dr. MCCLELLAN. Thank you for asking. I do have a few comments on it. While I think it is very important for us to look at input and feedback from any source, I am very concerned about the report being incomplete and inaccurate and out of date, at least as some people are interpreting its findings. I can tell you a little bit about that.

Mr. LEWIS. Doctor, the report is saying that much of the information that was sent out by you and CMS was inaccurate and misleading, incomplete, too complicated for seniors. It suggested that many of the seniors that you want to sign up, they have only a fourth-grade reading level, and that much of the information you sent out was for people who could read at a seventh-grade level or maybe a college level. Do you care to comment?

Dr. MCCLELLAN. Absolutely. Again, there is a lot more I can say about this, but on the specific point that you raised about reading level, first of all, we have not been able to see the methods that GAO used. We asked them to share them with us, but they would not release them. If it is as described in their summary statements, their reading level determinations are based largely on syllable counts, the number of syllables in the words in the documents that they reviewed, what we found is that is a partial but not complete way of looking at how easy materials are to understand. There are

some words that our beneficiaries need to know that have multiple syllables that many of them do understand, words like "Medicare" or "prescription" or "beneficiary." In cases where we use these, we will use the words to make sure that we are clear and accurate about what beneficiaries need to know. It does mean the syllable count goes up.

We have had our materials reviewed by many independent groups that focus on plain language and clear communications; and those results which we compiled in our response to the GAO had very different conclusions about the ease of readability of the materials. In fact, the Medicare new handbook has won awards for its plain language.

Mr. LEWIS. To consistently tell people to go on line; if you want information, go on line. Apparently 70 percent of the people that receive Medicare have never been on line and they never use a computer. They do not know anything about a Web site or iPod, whatever these things are.

Dr. MCCLELLAN. iPod things, whatever they are. I could not agree more that is why going on line is only a small part of our diverse grassroots outreach campaign. In Georgia we are partnering with faith-based organizations, counseling groups like Georgia Cares and the Georgia health insurance counseling organizations, to get into people's neighborhoods for face-to-face talking about what the drug benefit means for them.

People can also call us anytime. We have more than 6,000 customer service representatives, and that is why we have been able to get our minority enrollment, and that is why you have been able to get enrollment in your district to run ahead in our national average in many respects.

Mr. LEWIS. Do you think all of these are exceptional circumstances that would justify extending the May 15 enrollment deadline?

Chairman JOHNSON OF CONNECTICUT. Excuse me. It has just been called to my attention that Dr. McClellan has to leave at 4:00. There are enough Subcommittee members here so that if we each stick tightly to 5 minutes, we may not all get to question him. So, I would like to ask you to suspend the rest of your questions, since your time has expired, and anyone else who can keep their questioning to 4 minutes out of respect for other members so we can get through everybody, that would be great.

Dr. MCCLELLAN. We will be happy to answer more in writing. This outreach is very important to us.

Mr. LEWIS. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you. Mr. Johnson.

Mr. JOHNSON OF TEXAS. Thank you, Madam Chairman, I appreciate it. Listen, I think you guys have done a super job and I do not know if you have answered the question yet, but the effect of eliminating the May 15 deadline; have you talked about that already?

Dr. MCCLELLAN. We have and how that would reduce enrollment in the program.

Mr. JOHNSON OF TEXAS. How do you propose that half of the beneficiaries are not aware of the deadline?

Dr. MCCLELLAN. At this point, about 85 percent-plus of our beneficiaries have drug coverage that is secure. Mostly it is through the new Medicare drug benefit, and those beneficiaries do not need to focus at all on any deadline. They are in coverage. They are not going to pay any penalties. They got protection for the rest of their lives against high drug costs.

For the ones who are left, it is about 15 percent, and even half of those qualify for the low-income assistance, and they will have chances to enroll after May 15. So, it is really only a small part of our population that we still need to reach. We want to make sure they know about the deadline, but most people have moved on. They are using the coverage, they are saving money, and they are satisfied with it.

Mr. JOHNSON OF TEXAS. I agree with you. I would like you to emphasize that the lower income do not have a deadline, in effect. You will help them get the coverage regardless of the time frame.

Dr. MCCLELLAN. That is right.

Mr. JOHNSON OF TEXAS. What would happen among plans if the Secretaries were allowed to negotiate prices?

Dr. MCCLELLAN. Congressman, I get asked that question a lot, so I have made a point of discussing it with our actuary and his staff who did an independent evaluation of proposals. As he reiterated again recently, there is no evidence that government negotiation would lead to lower prices than what we are seeing with a strong and aggressive price negotiation that the drug plans have to use in order to get people to enroll in their plans. They have gotten prices way down and compared to our experience in Medicare Part B, where Medicare did cover some drugs using price regulation for a long time there, we have moved to a new competitive system for pricing the drugs and we have saved billions of dollars. So, according to our actuaries there is no evidence that price negotiation would drive down costs any more.

I think it is especially important to be careful about government controls on access to drugs, and which drugs you take, when there are so many new medications coming along and when beneficiaries being able to get access to the medicines they need is constantly changing and needs to stay up to date.

Mr. JOHNSON OF TEXAS. Choice and free enterprise work, do they not.

Dr. MCCLELLAN. It seems to.

Mr. JOHNSON OF TEXAS. Thank you very much.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Johnson.

Mr. Doggett.

Mr. DOGGETT. Thank you very much, Doctor, for your service and for your testimony. I wish you well in signing up as many people as you can possibly get. As much as I deplore what I think are many of the deficiencies in this legislation, I personally join in that effort to try to get as many people in the south Texas area that I represent signed up.

Dr. MCCLELLAN. Thank you.

Mr. DOGGETT. Just continuing with Mr. Johnson's line of questions then, I guess you have concluded, then, based on talking to

the actuary, that we should repeal the negotiation authority to the Veterans Administration that gets less expensive prescription drugs for our veterans than any of these plans provide under Part D.

Dr. MCCLELLAN. I do not think I would say that. The Veterans Administration is a good program for veterans. It works well for them.

Mr. DOGGETT. It sure is. You are familiar with the Families USA study that it is so good that it provides prices on, I think, the top 20 most prescribed pharmaceuticals that are about half what your best plans under Part D are providing.

Dr. MCCLELLAN. For the drugs that are on the Veterans Affairs (VA) formulary, that is true. A lot of drugs are not.

Mr. DOGGETT. That is a pretty significant savings. Even by any standard a 50 percent savings—I think to actually be accurate, it was 48.2 percent—less than the government is paying through the veterans program, where we negotiate prices, than we are paying under this great system that has been set up that we are talking about today. That plan also is one that has been evaluated by our staff over at the Government Reform Committee. They show that actually there has been an increase in prices of these Part D plans from December to February.

Does your office study the changes in prices that are available?

Dr. MCCLELLAN. We have been watching that very closely. We sent a response letter to Consumers Union, who also picked up on part of the same study that you saw that pointed out some of the problems with minority staff's study on the Government Reform Committee. Basically the only price changes that we are seeing are changes in the so-called Average Wholesale Price for a drug that applied to every program, including the VA. Many Medicare beneficiaries have chosen plans with flat copays that stay the same for the whole year for their drugs, and so are protected even from those kind of changes in prices. We would be happy to share with you the details of that. The prices and savings have remained stable over time, overall, and they have actually increased.

Mr. DOGGETT. I think it would be helpful to add as you filed other documents with your testimony, those studies as well—

Dr. MCCLELLAN. We will get that letter into the record.

Mr. DOGGETT [continuing]. that your actuary has provided that are critical or are objecting to price negotiation.

Dr. MCCLELLAN. We are happy to do that.

Mr. DOGGETT. As far as the study that my colleague, Mr. Lewis, was just asking about on the GAO, I understand you do not have all of your discussions back and forth between your staff and their staff about how they did what they did, but you are aware that they reported that one 1 of every 3 times that someone calls in to CMS, they get the wrong answer or they get no answer or they get an answer that is incomplete and inappropriate.

Dr. MCCLELLAN. Well, I would like to just correct your statement, because that is an incorrect interpretation of what the GAO did. They did not look at any actual calls that beneficiaries were making. They made up five questions and they looked at those questions which did not even apply to most of the tools that we have available. They did not really even look at our toolbox. They

dusted off a hammer and got that out and did not even look at our power tools. Our power tools, which are what most beneficiaries use when they call us, rely on personal information from the beneficiary. They tell us who they are, and then we give them personalized support in making a decision. The GAO did not even look at any of those calls, and that is the vast majority of calls that come into us.

If you look at the actual calls coming into the Medicare program, the satisfactory rate of beneficiaries that call us with the information they get is 87 percent and the ongoing evaluations of the accuracy of the answers is 93 percent. So, that analysis was not based on actual calls by actual beneficiaries, which is what we are really focused on.

Mr. DOGGETT. Perhaps we can pursue that—since the time is up—in a future hearing, because the actual report refers to incomplete, inaccurate, and unusable answers. I have hope you will file your response with your testimony.

Dr. MCCLELLAN. It is with the GAO report. You can see it now.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Doggett. The record really should note that the VA formulary excludes 20 of the 33 most common brand-name drugs used by seniors, and the VA system delivers drugs to only 429 VA pharmacies; whereas the Medicare prescription drug benefit is delivered to 54,371 pharmacies.

Mr. CAMP.

Mr. CAMP. Thank you, Madam Chairman.

Welcome. Dr. McClellan, this GAO report that we have heard referred to, it seems many of the observations they made were the early days of the program. How do you respond to the fact that it seems that GAO's findings really apply to information that is out of date?

Dr. MCCLELLAN. It is very much out of date. In our response to the GAO report, we listed what we have done on each of the four specific recommendations that the GAO made. Some of these were kind of technical recommendations. One of the main reasons they scored one question as being an inaccurate response is because we talked about the savings from generic drugs, for example, and they thought, well, if there is a generic version of a drug, you should not automatically tell a beneficiary about that. I personally think that is exactly what we ought to be doing because they can offer so much savings and they are exactly the same drug, but we have since modified our script to let people look first at the overall cost of their brand-name drug if that is what they really want.

Again, I do not think that is the right thing to do, speaking as a doctor, if you want to save money safely on your medications. So, in that area, in each area we have made major further steps in improving our tools since the report was done in January.

Mr. CAMP. I want to thank you for all the hard work your Agency has done in enrolling millions of beneficiaries in the prescription drug coverage. I also want to personally thank you for the responses to my office that have been very very timely. Over 70 percent of the seniors in my district are benefiting from the program and surveys show an overwhelming majority are pleased with their coverage.

My question is how is CMS and HHS working together to expedite approval of the patient assistance program? I have heard some concerns from people who were covered by one of the plans in the past. That is obviously changing. Can you comment on that?

Dr. MCCLELLAN. I sure can. The Office of the Inspector General has provided a clear road map for how manufacturers can continue their assistance programs, in addition to Part D, just as they had before. I am very pleased that a number of drug manufacturers like Schering-Plough, like Merck, have come forward and done the right thing and continued their programs.

I personally think it is unacceptable for any drug manufacturer to use the start-up of Medicare Part D as an excuse to cut back on assistance to beneficiaries who still could get help in addition to Part D. This should be a win-win for the manufacturers and for the drug beneficiaries when it comes to assistance programs, because many beneficiaries who previously needed the manufacturer program now qualify for extra help. They have got comprehensive payments for their drugs. There are still some that have incomes between, say, 150 or 200 percent of poverty that will get some help from the Medicare drug benefit but could use the assistance program in addition.

The Office of the Inspector General has provided a clear road map for how manufacturers can do that. Some of them, like Merck, did not even need to get a specific opinion for their own program because they are following the road map. That is what I hope all manufacturers will do.

Mr. CAMP. Thank you. Quickly, before my time expires, the pharmacists have been a big help in this program and many are concerned about timely payment. How is CMS addressing those issues?

Dr. MCCLELLAN. We are firmly supporting pharmacists and making sure their contracts are enforced for timely payment. If any pharmacist is having difficulty with a drug plan meeting the terms of their contract to pay on schedule, they should let us know. We have handled some complaints in that regard and gotten them resolved. At this point we are seeing a very low number of complaints related to payments being made according to a contract.

Mr. CAMP. Thank you very much.

Chairman JOHNSON OF CONNECTICUT. Thank you. It is very nice that the last three members to question have either 71 or 72 percent of their seniors signed up in this program.

Now we turn to Mike Thompson of California.

Mr. THOMPSON. How many people do I have signed up?

Chairman JOHNSON OF CONNECTICUT. In your district, 72 percent are signed up.

Mr. THOMPSON. Seventy-three thousand four hundred and nine-five, according to your data, Doctor. Thank you for providing that. What I do not know is how many of these 73,495 people that you have told me have signed up were not getting some sorts of benefit before? We have asked you or your office for a breakdown in those numbers, and we were told that that is not available. Will that be available sometime soon?

Dr. MCCLELLAN. I will certainly look into it. I know we have made available that information at the county level and we will

look into providing some additional numbers. We have put out an awful lot of information lately of these county-level breakdowns.

Mr. THOMPSON. I would be interested to have the county level. I have got all or part of seven counties, and I would love to see it on that basis, if nothing else because it is one thing to state for certain, as the Chair has been doing, that these people have received coverage under this program. Maybe they have. I hope they have. I hope the more people that we can get in the better, but I think it is important for us to know the facts of this. How many are getting it now that didn't have coverage before?

Dr. MCCLELLAN. Many are getting much better coverage. Many people in your district with Medicare Advantage plans have much more comprehensive coverage. Many have much more secure retiree coverage. That coverage had been going away. We are keeping it in place.

Mr. THOMPSON. If you give me the data that we asked for, we won't have to argue it across the dais. We will have it for sure.

Doctor, is it your understanding—and you may have covered this while I was out at another meeting, and I apologize if you have—is there any interest in, or do you suppose that we are going to extend this May 15 deadline?

Dr. MCCLELLAN. We do not have the authority to do that.

Mr. THOMPSON. Do you see, from your vantage, that happening?

Dr. MCCLELLAN. As I said before, what we are seeing, what I see when I go around the country is seniors who are focusing in on this because the deadline is coming up. Most people do not do their Christmas shopping in August. They wait until closer to the deadline, and now is when we have put tremendous resources and all of our partners around the country and in your district are doing a lot of work to help people get their questions answered and make a confident decision, so now is the best time to look into the program.

Mr. THOMPSON. I appreciate that, but I just want to point out that there was another deadline that has come and gone, and that was the deadline for States to take action to get folks into the program. The States, unfortunately, did not have a Federal Government partner that met its fair share of that deadline, and you guys did not meet your deadline, so different States have had to come up with funding to provide prescriptions to folks who otherwise would not have had prescriptions. As a matter of fact, in California there has been 815,700 prescriptions paid for by the State, at a total of \$60 million, just in the month of April; 178,000 at \$15 million.

So, I would hope that we are not holding the beneficiaries to a different standard than the Federal Government is having to hold up to. I would be interested in knowing when States, California included, can expect to get reimbursed for this.

On the issue of partners, I just want to point out that one of the best partners has been the State Health Improvement Plans (SHIPs), Health Insurance Counseling and Advocacy Programs (HICAPs) in California. If you look at the numbers, they are doing 20 times the normal caseload and they get about 80 cents per beneficiary for the work that they do. I would argue that you would

have just terrible statistics if it were not for these HICAPs and the like organizations in other States.

Now they are going to experience a further cut in their benefits. These are people—I have one small county that used to get 200 calls a month. Now they are getting 200 calls a day, and we are going to cut their funding. How do you determine what the funding is?

Chairman JOHNSON OF CONNECTICUT. I am sorry, I have to cut you off.

Mr. THOMPSON. Maybe you can get back to me.

Dr. MCCLELLAN. I want to make sure these are issues that I can clearly respond to. With respect to the State payment, we worked out a framework and a schedule for carrying out that framework with a bipartisan group of State Medicare directors. We are just kind of following their lead so that the States will get paid back in the way that is easiest for them. Your Medicaid Director, Stan Rosenstein, was one of the members of that Committee. We are implementing that on schedule. California sent in their first round of data for that process, and we will be carrying out the reimbursement according to schedule for the States that followed through on the approach that they wanted for this reimbursement process.

With respect to partners like HICAP, I could not agree more that they are tremendously valuable assets and partners in making this program available and effective for all of our beneficiaries. We have more than doubled the funding for HICAP over the last few years. I will permanently keep that funding level high. We have also vastly expanded the use of other partners in your district, around California and around the country, to help take some of the load of more personalized connections with our beneficiaries. We will keep that in place too.

Right now we are helping people find out about drug coverage. In the years ahead, it will be great for helping them close the prevention gap by using our preventive benefits and our drug benefits more effectively. So, this is a permanent new part of the Medicare program, and I want to support them much more strongly than has ever been the case in the past.

Chairman JOHNSON OF CONNECTICUT. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chairman. Thank you for your important leadership on the Medicare prescription drug benefit from day one. I also want to thank our two witnesses for your excellent testimony.

Dr. McClellan, my home State of Minnesota, thanks to the leadership of Governor Pawlenty, was one of the States that stepped up to the plate with Medicaid dollars to fill the gaps when there were initial problems with the dual-eligible population. I am sure you agree that seniors and people with disabilities never should have faced those difficulties. There were really some major problems during the start-up of the program. To your credit, when the States started filling up the gap, you stepped in and announced that CMS would reimburse States that did step up to the plate to fill the gap with dual-eligibles, and I appreciate your leadership at that time as well.

I have two questions. One, can you assure us that CMS is taking every possible step to ensure that dual-eligibles never face those obstacles again? Second, when can the State of Minnesota expect to be reimbursed?

Dr. MCCLELLAN. On the first question, as you said, starting on January 2 we began taking further steps to address the issues that arose for some of our beneficiaries. While the vast majority of our beneficiaries have been using the coverage effectively from the start, too many were having difficulty at the beginning, and so we took new steps like implementing new data transfer procedures with the States and the drug plans.

We now do bi-monthly checks, twice a month, to make sure the plans with dual-eligible beneficiaries have up-to-date and complete information on their enrollment data and their copayment data to make sure those steps are done correctly.

We have also worked with the States, where there had been trouble with handoffs, to eliminate those difficulties; and that has been an ongoing process. We have also implemented some further steps with the plans for more timely transfers of data and more effective monitoring of the charge information in the pharmacy computer system, the so-called "for our arts data."

As a result, we have seen a vast reduction in the rate of problems arising at the pharmacy counter, people being unable to fill their prescriptions easily.

We did not stop there. We also have in place a casework tracking system so if any beneficiary does have trouble, we have a well-established business process between us and the plans, to resolve it quickly. We have been seeing a declining number over time, from month to month, of the cases where we need to intervene and provide this help, but it is there. So, any beneficiary that is having difficulty can follow up with us to work to get that resolved as quickly as possible.

Mr. RAMSTAD. So, it is fair to say, in summary, that quality controls are in place?

Dr. MCCLELLAN. Absolutely, and we have been tracking—

Mr. RAMSTAD. When can the State of Minnesota, before my time runs out, expect to be reimbursed? I am asked that question all the time at home.

Dr. MCCLELLAN. That is right. Congressman Thompson asked that question as well. We have set up a process with the States that follows the procedure that the States wanted to follow to minimize their burden. There is a time frame in there. We need to get data from Minnesota on the people who they want reimbursement for, and then summary information on those claims. As long as Minnesota follows that schedule and that framework that we laid out, they will get reimbursement. I expect that generally to occur by June if they provide us the data that they have agreed to provide us.

Mr. RAMSTAD. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Mr. ENGLISH. Thank you, Madam Chair. Just to clarify something, Dr. McClellan, I think that you alluded to earlier. Today, as we know, the GAO released a report regarding CMS operations outreach and communications with beneficiaries about their op-

tions under the new Medicare program. We have referenced that earlier in this hearing. We are told that GAO found many times beneficiaries were given incorrect answers to basic questions, but it seems many of the observations made by the GAO, as has been noted, dated to the early days of the program.

First, how do you respond to the GAO findings directly, and is the information, in fact, yesterday's news? What has the CMS done to correct the issues highlighted by the GAO?

Dr. MCCLELLAN. Well, we have a number of concerns about the way the GAO report was presented, which I think makes it incomplete and inaccurate and out of date. It is incomplete in the sense that it didn't look at most of the tools that we actually use and that our beneficiaries prefer for getting information about the drug coverage.

For example, most of our beneficiaries give us their Medicare number when they call us or when they go on line, so that we can provide personalized assistance to them. The GAO did not evaluate that part of our outreach and education program at all. Even in the cases where they did look at our answers, they scored us as being inaccurate, when in fact they simply did not get information because they did not provide this beneficiary number.

Now we have made clear that you can get information even without providing a beneficiary number. When they actually looked at it, in the vast majority of cases they got the right answer. So, incomplete evaluation. Also, they asked questions like: Can people compute with paper and pencil their out-of-pocket drug costs for the standard plan? Well, we have tools that beneficiaries are using to compute their drug costs so they do not have to do it by hand. It is much more complete information on predicting your cost for a year than has ever been available in any insurance program. So, that was not evaluated. So, incomplete and inaccurate as a result of not really looking at our whole tool status. It is like taking a screwdriver and trying to use it to hammer in a nail, and not even using any of our power tools at all.

The evaluations of actual beneficiary calls during February and March have shown satisfactory rates by beneficiaries around 86, 87 percent, and accuracy rates for these calls, the actual calls that beneficiaries make, of 93 percent.

There are many other independent and third-party evaluations that have gone on before, during, and after this time of our tools as well that come to similar conclusions, and those are all incorporated in our response to the GAO.

Finally, as you said, it is out of date. This looked at the circumstances in January. We have made a lot of improvements in the program since then, including specific responses to the recommendations of the GAO. Our goal is to make sure that our beneficiaries can get the help they need when they want to enroll in coverage, and that is reflected now in the hundreds of thousands of calls that we are answering every day, the tens of thousands of people that are enrolling in coverage every day, and the very high rates of satisfaction with that coverage and the savings that our beneficiaries are getting.

Mr. ENGLISH. Thank you for your comprehensive answer which has exhausted my time. I yield back.

Chairman JOHNSON OF CONNECTICUT. Mr. Emanuel.

Mr. EMANUEL. Doctor, I know we talked earlier about some of the cost savings here. If I am not mistaken, the original price of the prescription drug bill was \$394 billion, and even with those savings it is way over \$394 billion. It is not even close as an evaluation. I think the number I saw the other day in the report is that it will come in at \$800 billion; and even, by standards in Chicago, that is twice as much as originally projected and originally told to Members on the floor.

So, I compliment that there has been a, quote-unquote, 20 percent savings over the trillion-dollar figure, but it is still twice as much as the original 400 billion or \$395 billion originally quoted on the floor and told to both Members, the public, and, most importantly, the taxpayers.

It gets to the issue—and we go around and around on this subject—as a leader and somebody who is taking the leadership both in reimportation as well as the issue of direct negotiations, I know you know of the study done by the Center for Economic and policy research, a nonpartisan group. You are familiar, I am sure, with the study.

Dr. MCCLELLAN. I do not think I looked at it recently, but I am sure I have seen it.

Mr. EMANUEL. They say there is \$40 billion worth of savings if you do what the VA does or Australia does, which is direct negotiations. Rather than have this fight of direct negotiations versus private subsidized plans, I still do not understand this ideological, almost theological obsession about negotiation. Why will we not have Medicare negotiate, private plans do theirs, and let the public choose which one they want?

If it is all about choice, which has been the rhetoric that you always say—and I appreciate that—why would we prevent choice?

Dr. MCCLELLAN. Beneficiaries do have a choice.

Mr. EMANUEL. No disrespect. I do know something about spin. I asked a specific question. Why would we prevent choice between direct negotiations by Medicare and the negotiations that either United Health, WellPoint, or any of the other plans provide? Why would we prevent the consumers, that is, the senior citizens, from having the choice, that basic market decision, because both choices—that competition would drive prices down. Why would we prevent the seniors from having choice, which was the selling point of this plan, which a number of us opposed?

Dr. MCCLELLAN. I am all for seniors having choice.

Mr. EMANUEL. Good.

Dr. MCCLELLAN. It has to be choices between specific real proposals, and I have not seen any specific real proposal along the lines that you have described that has been scored as saving money, that would operate in real neighborhood pharmacies, not the VA.

Mr. EMANUEL. Dr. McClellan, there has been from GAO to this study, we can submit: Listen, if you want go to my Web site, I will give you another choice. I list Costco in Chicago; Costco in Toronto; 500 miles apart. Costco, bulk purchaser, negotiator. The Costco in Toronto every month, and we update it for the same drugs, same milligrams, same doses. The Costco in Toronto is always over

\$1,000 cheaper than the Costco in Chicago. I will accept the theology of you and the philosophy of choice. Bought in. Done. Sold. Let's have a competition and choice between a Medicare negotiation price versus United Health, WellPoint, and any of the other 43 plans.

I want choice. Not a conscripted choice; a choice of direct negotiations or private market negotiations. Let's have choices and then let the consumer choose.

Dr. MCCLELLAN. I am not sure what the question is. If it is about should Medicare rely on drug importation for all of its seniors, I am not sure the numbers work out.

Mr. EMANUEL. That is not what I asked.

Dr. MCCLELLAN. Are you asking for a VA option in Medicare?

Mr. EMANUEL. Sure.

Dr. MCCLELLAN. That comes with—I would like to see the specific proposal, because that would come with a very narrow access to pharmacies, a 75 percent use of mail-order prescriptions rather than community-based prescriptions—which, as you know in Chicago, is the way that most of your seniors get their drugs now—and would come with a specific government-determined formulary and specific government-determined and government-paid staff positions, government-owned hospitals, a very strict network of care. It works great for VA beneficiaries.

I am not sure it is the model that Medicare beneficiaries in this country want. They like choices of doctors. They like choices of pharmacies. I would like to see the specific proposal.

Mr. EMANUEL. I spend time with seniors, since I have the oldest population of any of the 19 congressional districts in the country.

Chairman JOHNSON OF CONNECTICUT. I am sorry, Mr. EMANUEL. We do want to get through.

Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chairman.

Dr. McClellan, it has been suggested that perhaps you will do something about this May 15 deadline. While you are at it, would you do something about this pesky April 15 tax deadline while you are at it?

It was also referenced to you and your boss, Secretary Leavitt, when you and your other boss, the big boss, when you and the President came to Missouri recently—I mean no disrespect—the two of you were upstaged by the three Missourians on stage with you.

It is a constructive critique but exactly—the gentleman who is healthy, who did not take prescription drugs, who signed up anyway as you recall; or the woman, delightful woman who had 12 medications and she went on line and talked about the \$200 a month she was saving with the choice; and even the old dairy farmer who said he knew his way around a dairy cow but not around a computer, and yet 1-800-Medicare gave him real savings.

So, especially the steady success, even when our own colleagues and outside groups call public meetings just to bad-mouth the program, I think the success we have had on behalf of America's seniors has been extraordinary.

It was not that long ago we heard predictions, even within this room, even within this Committee, this will not work. Now we hear well, okay, maybe it is working but wait until the doughnut kicks in. We heard seniors will not have choices.

Now the complaint is too many choices. We heard we will have to legislate the premium because we could not guarantee a \$35 monthly premium. As you pointed out, now many seniors, 95 percent of which have access to premiums half that, should they choose to make it.

Again, it is great to see the progress and the aggressive efforts you have had.

Now, here is the question, to follow up on my colleague, Mr. Camp of Michigan. There are a number of independent pharmacists in my district, and I have a meeting with several of them coming up, in fact, on Monday back home in Columbia, and they are concerned about the new landscape. There is a suggestion out there—in fact the next panel will suggest that there needs to be some legislation, a prompt-pay legislation that would direct plans to pay electronically submitted claims within 14 days; other claims within 30 days. That is one proposal, one suggestion. I know there is another one about a set dispensing fee.

Let me yield to you, then. Are these good suggestions, why or why not?

Dr. MCCLELLAN. First, let me again express the tremendous gratitude that we have to the work that pharmacists all over the country have done, especially in those early weeks of the program when we were implementing a new benefit for more than 20 million people on the same day. They did a tremendous amount of work to help people get the drugs they need, and since that time have been giving us a steady stream of constructive ideas about how to make the program work better. Those ideas have translated into some steps that are reducing costs for pharmacies and helping them improve quality of care as well. I will talk about those in a second.

With respect to specific legislation, I would like to obviously talk to you more about any ideas. I am concerned about proposals that would get us directly involved in negotiating contracts or setting prices. Those tend not to keep up with modern medicine and may not lead to the most effective ways of dealing with care.

I would be particularly concerned about steps that might actually increase costs of drugs for beneficiaries and for the overall program. With that in mind, I think there are a lot of steps that we can and are taking together with the Nation's pharmacists to reduce their costs and improve quality of care.

Let me give you a couple of examples. With the National Community Pharmacists Association (NCPA) we have worked with the health plans to come up with a standard set of codes that are going to be used for most of the transactions that up until now have required pharmacists to look things up in a book or make a call to a health plan.

By having standard consistent coding in the pharmacy computers for things like prior authorizations or off-formulary drugs, we can reduce their administrative costs significantly and make their job

easier. That means more time for serving the beneficiaries that they really care about.

Second, we started a new collaboration called the Pharmacy Quality Alliance, partially led by the NCPA, but again working with health plans and consumer groups and really all of the health care stakeholders to do a better job of identifying and then supporting high-quality pharmacy care.

I am a physician. I have seen this in my own practice. You get squeezed with payment rates coming down, and it just gets harder and harder to make that up on the volume. So, what we want to do is support a business model I think many pharmacists want to pursue, where they get paid more when they take steps to help beneficiaries lower their drug costs and help them get better quality of care. There are so many ways pharmacists can do that: by helping to educate people about generics, by helping them with problems of medication interactions, by improving medication compliance.

Many patients don't comply with the prescription they get. That is the next challenge we will meet. We will do it with help from the pharmacists. So, there are a lot of steps we can take together to improve pharmacy business, improve quality, and reduce costs that I think might be worth pursuing in the short term.

Chairman JOHNSON OF CONNECTICUT. Dr. McClellan, if we could go to the two members who are not—

Dr. MCCLELLAN. Absolutely, I would be happy to stay for those.

Chairman JOHNSON OF CONNECTICUT. Mr. Herger of California.

Mr. HERGER. Thank you. Dr. McClellan, in your statement you write: For the 10-year period of 2006 to 2015 the net total costs of the drug benefit to Medicare is now estimated to be about \$130 billion less. In addition, the State phased-down contributions are now projected to be \$37 billion less. Not only have there been reductions in the cost of prescription drugs, market forces have allowed for more attractive alternatives for beneficiaries. In fact, CMS research has found that the majority of new enrollees have chosen plans offering a plan design other than the standard drug benefit.

Doctor, does CMS have plans to improve the display of comparable plan information, to make it easy as possible for Medicare beneficiaries to review plan options and make an apples-to-apples comparison?

Dr. MCCLELLAN. Congressman, we are taking steps to do that now that we have got a clearer idea of what beneficiaries value. As you said, it is not the standard benefit. If we had tried to come up and guess what benefit package they wanted I think we might not have gotten it right. Now that we are seeing what they actually want, we are setting up comparison systems that focus on the key dimensions that matter to beneficiaries.

What we are seeing that matters is the premium, the overall out-of-pocket costs for the drugs that can be expected; but also some important benefit features like whether or not there is a deductible, whether or not there is a co-insurance, meaning the beneficiary pays a percentage of the drugs, or a flat copayment, a flat rate; whether or not there is coverage in the so-called coverage gap.

Those dimensions seem to be very important to our beneficiaries and we are improving our side-by-side display of plans to help beneficiaries focus in the key dimensions that they are telling us are important to them in their own choices.

Mr. HERGER. Dr. McClellan, I want to thank you for the job you have done, looking at the magnitude of what you have done, the job to roll out this entirely new program.

I had a visit in one of my town hall meetings a few weeks ago with a pharmacist in one of my small communities of Weaverville, California, and to hear him say how good the program was working, how happy those that signed up were when they were coming in. As a matter of fact, he said because the costs were lower, they were actually purchasing more drugs. That was because they needed more and they could not afford it before.

So, again, I think you are doing a great job. We certainly have a ways yet to go, but considering the challenge, I want to commend you. Thank you, Madam Chairman.

Chairman JOHNSON OF CONNECTICUT. Thank you. Mr. Becerra.

Mr. BECERRA. Thank you, Madam Chair. Especially thank you for letting those of us who are not on the Subcommittee to ask questions.

Dr. McClellan, thank you very much for extending your stay here. We appreciate that very much. We hope you continue to work for that eventual goal of getting as many people enrolled as possible.

A quick question to you, and I am going to try to keep, Madam Chair, my questions under the 5 minutes. So, please feel free to gavel me as soon as that red light comes on, if it does.

The call centers. We know there are some issues with the call centers. The volume in some cases has increased and, obviously, for the next 2 weeks we expect it to be much higher than it has been in the past. I know you had a contractor go out there to monitor some of these call centers from some of these plans to find out what is going on. Some are not doing as good of a job as others.

Would it not be helpful for beneficiaries to have access to the information that this contractor found out about the call centers—who is doing well, who is not doing well—so that these beneficiaries can make an informed decision on which plan will suit them best?

Some plans have heeded your call to try to be more aggressive in handling the work that is coming through from those who are inquiring about their plans. Others are not. I would think that we would want to let the American public, the taxpayers, know which plans are really trying to do a good job of marketing themselves to those they will give money, or from whom they will get money to offer the plan.

So, you have this contractor who did this examination of the call centers from the various health plans. Why not make it available before the May 15 deadline so people can see which plans are really trying to do the work of attracting their business?

Dr. MCCLELLAN. We are doing all we can to monitor the plan performance and so we have got a contractor that is now checking

on the wait times. That full process has been in place just for a few weeks, and we do not yet have reliable data at the plan level.

What I can tell you is that we do want to make that available as soon as possible, when we have reliable estimates. What I can also tell you is some good news in terms of wait times. The vast majority of plans are answering the vast majority of calls in under 5 minutes. As we get more precise information, we will make it available.

Mr. BECERRA. Can I ask you what more you will be doing to try to make sure that folks who are not as proficient in English or are suffering from a particular disability, hearing disability, speech impediment, those who are going to have a little bit more difficulty trying in these last hairy weeks to make sure they do the right thing, that they are given access to people that can help answer the questions they will have on making a decision on which plan to enroll.

Dr. MCCLELLAN. That is very important to me because that describes a lot of our beneficiaries. We have not only ramped up our whole customer support staff. We have got more than 6,000 representatives. It is all hands on deck between now and May 15. We have also made sure that all of our help lines, all of our major Web pages, are available in English and Spanish. We have increased our partnerships with groups that specialize in other languages, more than 16.

Mr. BECERRA. The difficulty I have with what you just said is that we know that the vast majority of seniors, period, have not signed up to your Web page.

Dr. MCCLELLAN. Call lines, too.

Mr. BECERRA. You have a lot of folks who do not sign on to the Web page. Those who are limited English-proficient are less likely to sign on to the Web page as well, and have difficulties with your call center.

So, I hope what you will do is you will ramp up the services for those who are really trying to make informed decisions, but are not gaining access to people who can give them the information they need.

Dr. MCCLELLAN. That is why we are partnering with groups like the National Alliance for Hispanic Health. They are helping us with community-based events. We are doing faith-based events, I think, in your district. I want to thank you for the help with supporting many of those. It is that local grassroots outreach that is really making a difference with many of these hard-to-reach populations, and we are accelerating all of that between now and May 15.

Mr. BECERRA. Hopefully, May 15 can be moved back a bit. I know a number of us are very concerned. We appreciate that you at least came here to tell us a little bit about what is going on.

Thank you, Madam Chair. I yield back.

Chairman JOHNSON OF CONNECTICUT. As we close, want to take one last look at the chart that I talked about at the beginning. The tallest silo on the left shows that the earned income tax credit for the elderly, first passed in 1975, still reaches out to only 68 percent of the eligible seniors. Medicaid for the elderly only encompasses and touches 60 percent of the eligible seniors. Supplemental

security income reaches only 53 percent. Food Stamp reaches only 30 percent.

So, truly, Dr. McClellan, it is outstanding that you are moving now beyond the 70 percent and the 80 percent and looking at the possibility before the May 15 deadline and certainly through the low-income people that will register thereafter, you are looking at 90 percent of the 42 million seniors either in the Medicare program or in a position where they did not need it and therefore didn't sign up.

To have only 4 million left, I expect you will have by May 15, and with May 15 and the follow-on work of both agencies with the low-income seniors that have special eligibility, it is really a powerful performance that you and all the good workers at CMS and the SSA and your partners throughout the State and local governments and all of your many partners in the nonprofit sector have turned in.

The seniors have got it. They are signing up because they save money. They get protection from poor drug interactions. They get protection against catastrophic drug costs, equally important, they get to tailor the program to themselves.

I think it has been broadly missed that whether you go to the doctor or whether you do not, you pay \$88 a month for Part D. This plan, if you do not use drugs in my district, you can get the \$7.35 variety. In California, I understand they have a \$5.25 variety. I think in some other States they even have a lower cost variety than that.

If you use a lot of drugs, you can get the higher confident premium and being covered during the doughnut hole, so to speak.

So, what is nice about this program is that it is not one-size-fits-all; government could not provide that kind of choice to our seniors. Indeed, as they live longer, as they live healthier lives, having that kind of choice is extremely important. You, having that delivery system that you have built, is the only hope that Medicare can begin to focus on helping seniors use our health benefits, our preventive benefits, and lead healthier lives and be financially more secure, therefore.

So, thank you both very much for the hard work of you and all those behind you, and for your testimony here today. Thank you.

The Subcommittee will recess for about 10 minutes while we go over and vote. Maybe even less.

We are going to take the panel right away after the first vote, and we will be here, then, during the debate on the motion to recommit and part of the next vote. Then we will have to hear the rest of the panel when we come back. We will be back as soon as we can, probably 8 to 10 minutes, and proceed with Panel II.

Thank you very much Dr. McClellan and Ms. Disman.

[Recess.]

Chairman JOHNSON OF CONNECTICUT. The second panel will gather. We will reconvene. Ms. Everett, would you please proceed. Susan Everett of Medicare Today.

Thanks to my colleagues for getting back. We have about 15 minutes, 20 minutes.

STATEMENT OF SUSAN EVERETT, NORTH CAROLINA REGIONAL COORDINATOR, MEDICARE TODAY, RALEIGH, NORTH CAROLINA

Ms. EVERETT. Okay, I will talk fast.

Chairman Johnson and Members of the Subcommittee, thank you for the invitation to join you today and for the opportunity to testify regarding the implementation of the Medicare Part D prescription drug benefit.

My name is Susan Everett, and I am representing Medicare Today, a partnership of over 400 national and local organizations that have spent the last several months providing information to literally millions of Medicare beneficiaries.

I am a regional coordinator for Medicare Today and have been personally involved in numerous education and enrollment events in Virginia—Virginia, Kentucky, North Carolina, Tennessee, Maryland and West Virginia.

Let me begin by telling you a story about a woman I met at one of our events. Her name is Doris, and she is from Newport News, Virginia. Doris originally wanted nothing to do with the Medicare Part D benefit. She had heard so much negative commentary about it from critics who were quoted by the media saying it was too complicated and wouldn't save anyone any money. She was so discouraged by what she heard that she decided it wasn't for her.

Then Doris ran into some health complications that required a new prescription costing more than she could afford on her fixed income. Her sister convinced her that she should at least come to the Medicare Today event that we were doing in her community to learn a little about the program firsthand.

Well, once Doris got there, we not only ran her information through the CMS plan finder and found a plan that would save her money, but we also connected her with the SSA official on site and got her enrolled for low-income assistance. Today Doris doesn't have to wonder whether she can afford her medicine or not.

Doris' story goes to the heart of my testimony today. The Part D implementation process has, by and large, worked. It hasn't been perfect, but I don't see how any program of this magnitude could be perfect in its first year of operation. Because the Centers for Medicare and Medicaid Services created tools for beneficiaries to use to find the best plans for their circumstances, and because so many organizations like ours are on the ground, interacting every single day with beneficiaries, the implementation process has been a positive one.

In 2005 and thus far in 2006, Medicare Today has conducted over 2,500 beneficiary events. We have provided information to over 5.5 million beneficiaries and helped enroll over half a million, not counting those who enrolled on their own after attending one of our events. We have trained 175,000 people in all 50 States so that they are qualified to help Medicare beneficiaries enroll in the Part D program.

I could fill the rest of this evening with anecdotes about people who have been helped through this effort, but I want to give you some empirical evidence as well regarding the effectiveness of the implementation effort.

The Medicare Today partnership commissioned an American viewpoint survey of 1,000 seniors in April, asked whether enrolling was easy or difficult. Seventy-two percent said they found it very or relatively easy, to just 20 percent who said it was very or relatively difficult.

We also asked those who were self-enrolled if they encountered any problems in enrolling; 89 percent said they had no problems. I think these are very solid results for a major program in its first year of existence.

We have learned a great deal over the past few months. We have learned that advertising and mass messaging is important, but is not a substitute for meeting people and answering their questions face to face. We have learned that to reach low-income seniors and to get them the assistance they need, you have to work through established systems such as Meals-on-Wheels programs and subsidized housing facilities.

We have also seen the value of public-private partnerships, having worked very successfully with SHIP programs and Area Agencies on Aging. A good example of this collaborate effort is seen in the work of one of our partners, Ascension Health, and its many hospitals and health services throughout the country.

In Bridgeport, Connecticut, to name one instance, the parish nurses of Ascension St. Vincent Health Services worked with the State to have computer-equipped vans at churches to educate and enroll parishioners. This type of effort has been very successful and well received.

I want to thank the members of this Subcommittee and this Congress for creating this drug benefit for my new friend Doris in Virginia and the millions more like her whose lives are made better by it.

I hope I have given you a useful on-the-ground perspective on what I believe has been a very successful enrollment process. It is my hope and belief that the lessons we have learned will make the next open enrollment period even more productive and problem-free.

Thank you, and I will be pleased to answer your questions.

Chairman JOHNSON OF CONNECTICUT. Thank you very much.

[The prepared statement of Ms. Everett follows:]

Prepared Statement of Susan Everett, North Carolina Regional Coordinator, Medicare Today, Raleigh, North Carolina

Chairman Johnson and Members of the Subcommittee. Thank you for the invitation to join you today and for the opportunity to testify regarding the implementation of the Medicare Part D prescription drug benefit.

My name is Susan Everett, and today I am representing the *Medicare Today* partnership, an alliance of over 400 organizations representing seniors, patients, health care providers, employers, caregivers and many others. The members of *Medicare Today* have spent the last several months working personally with Medicare beneficiaries, providing information and enrollment assistance to literally millions of individuals. I am a regional coordinator for *Medicare Today* and have personally been involved in numerous education and enrollment events in Virginia, Kentucky, North Carolina, Tennessee, Maryland and West Virginia.

Let me tell you a little about what I have learned from meeting with and assisting hundreds of Medicare beneficiaries, and then I'll be pleased to answer your questions.

When the Part D enrollment period began last November, I will admit that my optimism was guarded. We were introducing people to a brand-new program, and seniors tend to be naturally skeptical consumers. And that skepticism was heightened by the amount of negative commentary in the media from people saying the program wouldn't work, it wouldn't really save seniors any money, it was too complicated.

I met, for example, with a woman named Doris from Newport News, Virginia. She had heard so much negative commentary about the Medicare drug benefit that she really wanted nothing to do with it. Then, after she had some health complications that required a new prescription costing more than she could afford on her fixed income, her sister convinced her that she should at least come to the *Medicare Today* event we were doing in her community because she had nothing to lose from hearing a little about the program.

Well, once Doris got there, we not only ran her information through the CMS PlanFinder and found a plan that would save her money, but we also connected her with the Social Security Administration official on site and got her enrolled for low-income assistance. Today, Doris doesn't have to wonder whether she can afford her medicine or not.

And Doris's story goes to the heart of my testimony today, Chairman Johnson. The Part D implementation process has, by and large, worked. It hasn't been perfect. I don't see how any program of this magnitude could be perfect in its first year of operation. But because the Centers for Medicare and Medicaid Services has created tools for beneficiaries to use to find the best plan for their circumstances, and because so many organizations like ours are on the ground, interacting every single day with beneficiaries, the implementation process has been a positive one.

We come to this conclusion from considerable experience. In 2005 and thus far in 2006, *Medicare Today* has conducted over 2,500 beneficiary events, almost 500 of them in coordination with members of Congress. We have provided information to over 5.5 million beneficiaries and helped enroll over half a million, and that does not include the people who enrolled on their own after attending one of our events. We have trained over 175,000 people in all 50 states, so that they are qualified to help Medicare beneficiaries enroll in the Part D program.

We've learned a great deal as we've gone along. We've learned, for example, that advertising and mass-messaging is important, but it is not a substitute for meeting people face-to-face and being able to answer their questions about a brand new program. We've learned that to reach low-income seniors and help them get the assistance they need, you have to work through established systems, such as meals-on-wheels programs and subsidized housing facilities. And we have also worked, from the beginning, with SHIP programs and area agencies on aging with great success. We've learned over the last few months that these public-private partnerships can make considerable progress in locating and linking people with the benefits they need.

A good example of this collaborative effort is seen in the work of one of our partners, Ascension Health, and its many hospitals and health services throughout the country. In Bridgeport, Connecticut, for example, Ascension's St. Vincent's Health Services hosted several events at their facilities and St. Vincent parish nurses worked with the state and with the Area Agency on Aging to have computer-equipped vans at churches to educate and enroll parishioners. This type of effort has been very successful and well-received.

It is my hope and belief that the lessons learned by us, by CMS, and by other groups like the Medicare Rx Education Network, the ABC Rx Coalition, AARP and others will make the next open enrollment period even more successful and problem-free.

I can share with you my personal experiences, but I can also offer some empirical evidence. The *Medicare Today* partnership commissioned the American Viewpoint public opinion research firm to do a survey of 1,000 seniors in April regarding the Part D enrollment process. Asked whether enrolling was easy or difficult, 72 percent said "very or relatively" easy compared to just 20 percent that said "very or relatively" difficult.

We asked those who were self-enrolled if they encountered any problems in enrolling. 89 percent said no. Only eight percent said yes. I think these are very solid results for a program in its first year, especially one that was launched amidst so much criticism.

Chairman Johnson, there is certainly more I could say, were it not for the time limitations. Let me leave you, though, with one anecdote that occurred recently at a *Medicare Today* event near Lexington, Kentucky.

At this event, I met an elderly gentleman who wanted to learn more about the Part D program. I learned through our conversation that he could not read or write,

so that meant it took quite a bit of extra time to explain the process to him and to tell him how a prescription drug plan would work for he and his wife. As our conversation continued, I also learned that he and his wife had been cutting pills in half, skipping some of their doses and not getting prescriptions filled because they couldn't afford them. It was an emotional moment for both of us when I explained that he would save nearly \$300 per month and wouldn't need to cut pills in half anymore.

I want to thank the members of this subcommittee and this Congress for creating this drug benefit, for this gentleman in Kentucky and the millions more like him whose lives are made better by it. I hope I've given you an on-the-ground perspective on the enrollment process, and I will be pleased to answer your questions.

Chairman JOHNSON OF CONNECTICUT. Dr. Schiesser.

STATEMENT OF HEATH SCHIESSER, PRESIDENT, PRESCRIPTION DRUG PLAN, WELLCARE HEALTH PLANS, INC., TAMPA, FLORIDA

Mr. SCHIESSER. I am not a physician, but I am flattered.

Good afternoon. I am Heath Schiesser, president of Prescription Drug Plans for WellCare Health Plans. I appreciate this opportunity to testify about the implementation of the Medicare Part D program.

WellCare has been privileged to serve Medicare beneficiaries for more than 10 years. According to the most recent data from CMS, approximately 850,000 Medicare beneficiaries are enrolled in prescription drug plans offered by our company in all 50 States. Another 70,000 beneficiaries received prescription drug coverage through our Medicare Advantage health plans. WellCare is strongly committed on a long-term basis to meeting the health care needs of Medicare beneficiaries.

We applaud Congress for enacting the Medicare Modernization Act of 2003. We thank CMS for its tremendous work in achieving a largely successful implementation of the Part D program.

My testimony today will focus on three areas: First, examples of the savings and the value of the Part D program is delivering to beneficiaries; second, steps we are taking to communicate with beneficiaries and further strengthen the program; third, the importance of providing options to beneficiaries.

WellCare is giving beneficiaries the option of choosing prescription drug coverage that goes well beyond the minimum requirements established by the MMA. We are offering three PDP alternatives across the Nation, all of which offer a \$0 generic drug copay with no deductible and low premiums.

We also offer Medicare Advantage plans that offer Medicare Part D coverage, along with lower physician and hospital copays, for no monthly plan premium, including no Part D premium, in 50 counties across 6 States.

To more clearly illustrate the value the Part D program is delivering to Medicare beneficiaries, I would like to review the experiences of two seniors who are enrolled in a WellCare prescription drug plan. Mike is a Medicare beneficiary in California, who will probably save about \$2,400 this year as a member of a WellCare plan. He is taking six prescriptions that would cost about \$520 per month retail. By comparison, with our discounts and the coverage provided by Part D, he will save about 38 percent this year.

Ann is a Medicare beneficiary in New Hampshire, who will probably save about \$700 this year and avoid the coverage gap as a member of our Signature plan. She is taking two drugs whose combined cost ordinarily would cause her to reach the coverage gap in about November. However, by switching to generic alternatives, Ann's monthly drug care cost will probably drop to about \$70 per month, which will allow her to avoid coverage gap entirely. Even better, since the WellCare Signature plan is zero dollars for generic copays, her monthly copays for those drugs will be zero. As a result, Ann's monthly premium of about \$24 for her Part D plan will probably be her only expense on prescription drugs for the entire year.

As for how we are working to strengthen the program, I would like to briefly highlight three key areas. First, in January, Part D programs across the Nation experience extremely high call volumes, largely because of problems of eligibility data and operational difficulties in pharmacies. WellCare moved quickly to adopt corrective measures, dramatically increasing our staff, working overtime, and refining our process.

Between January and April, we increased our staffing by approximately 75 percent. Today WellCare is consistently delivering service in excess of CMS requirements. Our average time to answer has been under 20 seconds over the last 2 months.

Also, we adopted transition plans in January, which CMS subsequently required all plans to extend to March 31. As we approach the end of this transition period, we took a number of steps to ensure a smooth shift into the normal application of our formulary, which have proven to be successful.

Finally, at the industry level, WellCare and other plan sponsors have been working through our national trade association, AHIP, to address implementation issues in collaboration with the leading pharmacy and physician groups.

These are just a few examples of the strong measures that WellCare and our industry as a whole are taking to help strengthen the Part D program and assure its long-term success.

I also want to briefly note our concerns with proposals that would standardize benefit packages under the Part D program. We believe this is a bad idea for several reasons. First, millions of beneficiaries would be forced to leave the benefits they have chosen and enter into a standardized plan that may not be the best option for their specific needs.

Second, the standardization approach underestimates the abilities of beneficiaries to make thoughtful, informed choices.

Finally, we think that instead of focusing on limiting choices, we need to be focusing on providing beneficiaries with better information.

Third, the standardization proposals overestimate the ability of the experts to design benefits that will meet the beneficiaries' needs.

In closing, I hope you will agree that the Part D program is providing significant value to beneficiaries, that WellCare and other sponsors are working hard to ensure the success of the program, and that beneficiaries are well served by a program that gives them a wide range of choices.

Thank you for the opportunity to testify. I look forward to answering any of your questions.

Chairman JOHNSON OF CONNECTICUT. Thank you very much.

[The prepared statement of Mr. Schiesser follows:]

Prepared Statement of Heath Schiesser, President, Prescription Drug Plan, WellCare Health Plans, Inc., Tampa, Florida

I. INTRODUCTION

Good afternoon, Madam Chairwoman and Members of the Subcommittee. I am Heath Schiesser, President of Prescription Drug Plans for WellCare Health Plans. For over 10 years, WellCare has been serving Medicare beneficiaries through health plans that offer high quality, comprehensive, affordable coverage. More recently, as participants in the new Medicare Part D prescription drug program, we have launched three new stand-alone Medicare prescription drug plans providing coverage that became effective on January 1, 2006. We consider it a great privilege to be able to serve Medicare beneficiaries throughout the nation.

We appreciate this opportunity to testify about implementation of the Medicare Part D program. According to the most recent data released by the Centers for Medicare & Medicaid Services (CMS), approximately 850,000 Medicare beneficiaries have enrolled in Part D prescription drug plans offered by WellCare in all 50 states. Another 70,000 beneficiaries receive prescription drug coverage through WellCare's Medicare Advantage health plans.

WellCare is strongly committed to meeting the health care needs of Medicare beneficiaries and we are excited about our participation in the new Part D program. This program, along with other provisions of the Medicare Modernization Act of 2003 (MMA), is providing important benefits and peace of mind to millions of Medicare beneficiaries. We applaud Congress for enacting this landmark legislation, and we thank CMS for its tremendous work in achieving a largely successful implementation of the Part D program within a relatively short period of time.

In our testimony today, we will focus on: (1) the savings and value the Part D program is delivering to both beneficiaries and taxpayers; (2) the critically important role that competition based on benefit design has played in the program's success; (3) the experiences of beneficiaries who have enrolled in WellCare's Part D plans; and (4) specific steps WellCare and other plan sponsors are taking, in collaboration with CMS and other partners, to strengthen the program.

II. PART D IS PROVIDING VALUE TO BENEFICIARIES AND TAXPAYERS

WellCare and other Part D sponsors are delivering more comprehensive benefits at a lower cost than the experts had predicted before plans developed their benefit packages for 2006. This outcome is largely a result of the fact that plans have developed a number of tools and techniques that have proven to be highly effective in making prescription drugs more affordable for consumers. This positive outcome is also a result of the success of the MMA legislation in creating strong and vibrant competition among health plans which has led to lower costs and better benefits for Medicare beneficiaries.

WellCare is giving beneficiaries the option of choosing prescription drug coverage that goes well beyond the minimum requirements established by the MMA. WellCare offers three PDP alternatives across the nation. All three plans offer \$0 generic drugs without any co-pay, no deductible, and low premiums starting as low as \$17.13 in New York and averaging \$22 across all our members. (Of course, our full-dual and low income subsidy members have their premiums paid entirely by Medicare.)

WellCare also offers Medicare Advantage plans with Part D drug coverage in 53 counties that are home to more than 5.2 million Medicare beneficiaries. In all of these counties, WellCare offers plans that provide Part D coverage, plus lower physician and hospital co-pays, for no monthly plan premium—including no Part D plan premium. Furthermore, in 40 of those counties, 4.4 million beneficiaries have access to a WellCare plan with no monthly plan premium and \$0 generics in the coverage gap.

Much like WellCare, a wide range of plans across the nation are offering coverage that exceeds expectations. Many plans—including WellCare's Medicare Advantage plans—are providing additional benefits in the MMA-established "coverage gap" that begins after a beneficiary's annual drug expenditures exceed \$2,250. Under the MMA, the standard benefit includes a coverage gap in which beneficiaries would pay 100 percent of their total drug costs exceeding \$2,250 until their out-of-pocket

expenditures reach \$3,600. However, in all 50 states, beneficiaries have the option of choosing a Part D plan that covers a portion of the costs in this coverage gap.

The value offered by Part D plans also can be seen in the lower-than-expected premiums that beneficiaries are paying. Before plans submitted their benefit packages for 2006, beneficiary premiums were projected to average \$37 a month. However, according to CMS, the average premium for all prescription drug plans nationwide is actually \$30 a month—almost 20 percent lower than originally expected—with a number of plans offering premiums that are far lower.

In addition, many plans have deductibles below the \$250 maximum standard, including 58 percent of all stand-alone prescription drug plans that offer zero deductibles.¹ According to CMS,² 69 percent of beneficiaries in stand-alone prescription drug plans and 89 percent of beneficiaries in MA-PD plans have selected options offering zero deductibles.

Savings Generated by Competition

Overall, HHS has reported³ that beneficiaries who previously did not have drug coverage are now saving an average of \$1,100 on their annual prescription drug costs by enrolling in the Part D program. Moreover, a recent CMS analysis⁴ found that beneficiaries who select the lowest-cost plan in their area can save up to 71 percent relative to the amount they would pay without prescription drug coverage.

While all types of beneficiaries can save money by choosing Part D plans, financially vulnerable beneficiaries can expect to receive exceptionally large savings because of the low-income subsidies the MMA provides. On average, Medicare will pay more than 95 percent of prescription drug costs for these low-income beneficiaries.

The savings available to low-income beneficiaries are measured by an August 2005 study, performed by PricewaterhouseCoopers,⁵ which concluded that beneficiaries with incomes at or below 150 percent of the federal poverty level and who are not on Medicaid can expect to see their annual out-of-pocket prescription costs drop from an average of \$1,657 to \$180 by participating in the new drug program. Another more recent study, conducted by the Lewin Group,⁶ found that beneficiaries without previous drug coverage who have one or more of five chronic conditions—arthritis, diabetes, hypertension, osteoporosis, or respiratory illness—can save 58 percent on their drug costs by enrolling in a Part D plan.

According to CMS data, the number of beneficiaries who are choosing this new benefit and receiving these savings is increasing by more than 400,000 with each passing week. The agency recently announced that, as of April 18, almost 20 million Medicare beneficiaries were receiving prescription drug coverage through either stand-alone Part D prescription drug plans or Medicare Advantage health plans. Another 6.8 million beneficiaries are benefiting from Part D subsidies that are partially supporting their retiree health benefits. Overall, the total number of Medicare beneficiaries with prescription drug coverage now exceeds 30 million.

Taxpayers also are benefiting from plans' success in delivering quality prescription drug coverage at an affordable price. HHS has announced⁷ that the savings generated by competition in the Part D program are greater than expected and are reducing costs for Medicare. Since July 2005, the projected cost of the Part D program for 2006 has declined by \$7.6 billion. Similarly, projected program costs for the next five years have declined by \$30 billion according to HHS' most recent estimates. These lower-than-expected costs mean that taxpayers are receiving high value for the dollars they invest in the Part D program.

Sustaining These Benefits

Our experience at WellCare suggests that benefit design matters. We have seen strong enrollment in our plans precisely because we have developed plans that are meeting beneficiary needs. While some suggest that standardization of benefits would simplify the program, proponents of this approach are overlooking the reality that innovation will continue to flourish as long as plans are competing based on

¹ AHIP analysis of CMS data, November 2005.

² CMS, Presentation by Abby Block, Director of Centers for Beneficiary Choices, April 5, 2006.

³ HHS, *Secretary's Progress Report II on the Medicare Prescription Drug Benefit*, February 22, 2006.

⁴ CMS Office of Policy, *Analysis of Savings Available Under Medicare Prescription Drug Plans*, March 1, 2006.

⁵ PricewaterhouseCoopers, *Medicare Tomorrow: Future Savings for Beneficiaries*, August 25, 2005.

⁶ The Lewin Group, *Chronic Health Conditions & the New Medicare Part D Benefit: Savings on Frequently Used Medications*, April 12, 2006.

⁷ HHS, *Secretary's Progress Report II on the Medicare Prescription Drug Benefit*, February 22, 2006.

their ability to design benefits that are appealing to beneficiaries. This element of competition is critically important in sustaining the high quality, comprehensive, affordable options that beneficiaries are seeing in this first year of the Part D program.

A review of the program indicates that plans are offering different benefit packages, allowing beneficiaries to choose options that better meet their needs with coverage that goes far beyond the minimum requirements. It would be a serious mistake for Congress to undermine these choices by requiring plans to adhere to rigid standardization requirements. Allowing the market to produce high quality choices through healthy competition is a much more effective way to meet beneficiaries' needs than mandating one-size-fits-all benefits packages.

The vast majority of beneficiaries have responded to these choices by selecting benefit packages that differ from the minimum requirements set by the MMA. CMS data⁸ show that the standard defined benefit has been selected by only 16 percent of beneficiaries in stand-alone prescription drug plans and by only 5 percent of beneficiaries in Medicare Advantage plans with prescription drug benefits (MA-PD plans). All other beneficiaries are choosing plans that offer enhanced benefits or alternatives to the standard benefit.

The value of choice has been demonstrated by WellCare for years in our Medicare Advantage business. For example, in Broward County, Florida (the Fort Lauderdale area), we offer three plans: Choice, Value and Dividend, each of which have attracted a large number of members. All three plans offer Part D coverage with \$0 generics and no deductible. They also offer reliable co-pays rather than co-insurance, and lower physician and hospital costs for Medicare beneficiaries.

- The Choice product offers co-pays of \$0, \$10 and \$50 for primary care physician (PCP) office visits, specialist office visits, and per-day hospital charges for the first five days in the hospital. Choice also offers \$0 generics in the coverage gap.
- By comparison, our Value product offers \$0 co-pays for PCP office visits, specialists and hospital stays, but does not provide coverage in the coverage gap.
- Finally, the Dividend product has higher co-pays of \$0, \$15 and \$50 with no coverage in the coverage gap, but refunds \$87.70 per month towards the member's Medicare Part B premium.

To summarize, these three products offer beneficiaries the choice of coverage in the gap, \$0 co-pays, or over \$1,000 a year toward Part B premiums. These are meaningful differences that recognize the fact that beneficiaries want a range of options to meet their particular needs and circumstances.

There is another advantage to having plans compete based on benefit designs. This approach creates incentives for innovation and makes the marketplace competitive. Just look at WellCare's success in signing up people into its PDP programs. We did not do it with a big, nationally recognized brand name like AARP or Blue Cross. Despite being well known and respected in many of our markets, WellCare is virtually unknown in most of the country. Nor can our success be attributed to an expensive advertising campaign. Rather, I believe WellCare attracted members by providing a distinctive benefit package with \$0 generics and no deductible. And as long as there is flexibility in creating different benefit packages, there will continue to be vibrant efforts to better understand and meet the needs of Medicare beneficiaries.

Tools and Techniques for Increasing Value

WellCare is able to offer high quality, affordable coverage through the Part D program because we have developed tools and techniques to reduce out-of-pocket costs for beneficiaries and, at the same time, improve quality by reducing medication errors and promoting clinically sound drug use.

Drug Interactions: Before Part D, if a Medicare beneficiary purchased drugs at more than one retail location, or perhaps via the mail, no one entity had a complete picture of all the drugs that he or she was taking. Now, through their pharmacy benefit manager, plans are able to review all the drugs that an individual is taking and identify potentially dangerous interactions before the drug is dispensed to the member. Likewise, plans are also able to monitor dosages and frequently abused drugs, like narcotics, and assure that they are treated appropriately.

Screening for Excessive or Sub-Therapeutic Dosages: In some instances, we have received requests for up to 900 tablets of a drug whose normal 30-day supply is only 30 or 60 tablets. Recognizing the potential for abuse, we typically will contact the prescribing physician to determine if the prescription is appropriate. Another cir-

⁸ CMS, Presentation by Abby Block, Director of Centers for Beneficiary Choices, April 5, 2006.

cumstance in which we may take similar action is when we receive requests for low dosages of a schizophrenia drug that is sometimes used off label as a sleeping aid—a usage that could have a detrimental effect on a patient's health.

Encouraging Generic Drug Use: One of the most important steps Medicare beneficiaries can take to minimize their drug costs, and in many cases avoid the coverage gap, is to utilize generic drugs, which cost on average less than 20 percent of their brand counterparts. We encourage this by designing products with \$0 generic drug co-pays and by adopting system edits that substitute generic drugs for more expensive brand name drugs. In addition to helping WellCare keep plan premiums low, this approach minimizes the cost to the beneficiary and makes the most of the coverage that Medicare Part D provides. Interestingly, over 80 percent of the most prescribed brand drugs have a generic therapeutic alternative available. Of course, if the member's physician has particular concerns that make the generic an unacceptable alternative, then the member can continue to take the more expensive brand name drug.

Discounts: Another way WellCare helps beneficiaries avoid the coverage gap, or help them minimize costs if they do reach the coverage gap, is by negotiating attractive discounts with retail pharmacies. For example, WellCare has negotiated prices that are more than 15 percent below typical cash prices. This clearly helps beneficiaries make the most of the Part D benefit.

I recognize that there has been some concern about the effect of Part D on independent pharmacies. A few facts to clear the air. First, of the 52,000 pharmacies in our network, approximately 16,000 are independent and are valuable partners in serving our members. They are an important part of our nation's system for delivering drugs to members. Second, our payments to independent pharmacies are, on average, about 1–3% higher than our payments to chain pharmacies. Third, our payments to independent pharmacies are timely; we receive bundled claims from our pharmacy benefit manager twice a month and we typically pay these claims, by electronic wire transfer, within 3 to 5 days after receiving them.

Formularies: Formularies, which also play an important role in controlling costs, must comply with stringent standards which ensure that they include drugs necessary to treat all major diseases. Medical professionals play a central role in developing formularies. To ensure that formulary decisions are clinically appropriate, health plan Pharmacy & Therapeutics Committees—comprised principally of physicians and pharmacists—identify drugs for inclusion on health plan formularies based on documented safety, efficacy, and therapeutic benefit.

A number of studies demonstrate that these strategies are highly effective in making prescription drugs more affordable for consumers. For example:

- The Congressional Budget Office (CBO) has estimated⁹ that private sector management techniques employed by Medicare Part D plans would save individuals 20–25 percent off retail prices for prescription drugs.
- A 2003 study,¹⁰ conducted by Associates and Wilson on behalf of America's Health Insurance Plans (AHIP), found that the PACE program in Pennsylvania—the largest state pharmacy assistance program in the nation—could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.
- In addition, the Government Accountability Office (GAO) has reported¹¹ that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average cash price customers would pay at retail pharmacies.

These findings clearly demonstrate that the private sector has a strong track record of using its experience and capabilities to deliver affordable prescription drug benefits. At a time when federal resources are severely strained, it is important for policymakers to recognize the ability of health insurance plans to implement strategies that are enabling Medicare beneficiaries to receive the greatest possible value for the dollars the Medicare program is spending on their prescription drug coverage.

⁹ CBO, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004.

¹⁰ Associates & Wilson, *Prescription Drug Benefit Management: Improving Quality, Promoting Better Access and Reducing Cost*, October 2003.

¹¹ Government Accountability Office, *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees, and Pharmacies* (GAO-03-196), January 2003.

III. Beneficiary Experiences and Attitudes

To more clearly illustrate the value the Part D program is delivering to Medicare beneficiaries, I would like to review the personal experiences of two seniors who are enrolled in WellCare's prescription drug plans. These real world examples demonstrate that beneficiaries are achieving significant savings on their prescription drugs by choosing Part D plans.

"Mike" is a Medicare beneficiary in California who will probably save about \$2,400 this year as a member of a WellCare plan. He is taking six prescriptions that would cost about \$520 per month at retail. By comparison, with WellCare's pharmacy discounts and the coverage provided by Medicare Part D, he will save about 38 percent this year.

"Ann" is a Medicare beneficiary in New Hampshire who will probably save about \$700 this year and avoid the coverage gap as a member of WellCare's Signature plan. She is taking Nexium and Clarinex, which average about \$240 per month combined at retail prices, or about \$2,500 over the course of the year with our discounts. At that rate, she would reach the coverage gap in about November and spend about \$250 in the coverage gap. By switching to generic alternatives, her monthly total drug cost will drop to about \$70 per month, which will allow her to avoid the coverage gap entirely. Even better, since the WellCare Signature plan has \$0 generic co-pays, her monthly co-pays for those two drugs will be zero. As a result, Ann's monthly premium for her Part D plan will be her only expense on prescription drugs for the entire year.

While these examples provide just a brief glimpse at the success of the Part D program, the experiences of these Medicare beneficiaries are not uncommon. Numerous surveys show that a large percentage of the overall Medicare population is pleased with the new program and the benefits it is delivering.

In early March, Ayres, McHenry & Associates conducted two surveys to evaluate the attitudes of beneficiaries who already were covered by Part D plans. One survey¹² focused on beneficiaries who chose plans on their own and the other focused on dual eligibles who were automatically enrolled in the program. Among seniors who voluntarily signed up for the program, 59 percent said they already were saving money and more than 80 percent reported that they had no problems related to enrollment or usage of their new benefits. Additionally, 65 percent of enrolled seniors said they would recommend that other seniors sign up for the program, versus 8 percent who said they would not.

The other survey¹³ found that among seniors who are dually eligible for both Medicare and Medicaid, 90 percent said they had experienced no problems using the new Medicare drug benefit. Another 4 percent said they had a problem that was resolved, while 4 percent said they had a problem that was not yet resolved.

In recent weeks, these findings have been reinforced by numerous other surveys indicating that beneficiaries are well-served by the Part D program. These survey findings clearly indicate that a large majority of Part D enrollees already are saving money, have not had problems signing up for or using their new benefits, and would recommend the program to others.

IV. PLANS ARE WORKING TO FURTHER STRENGTHEN THE PROGRAM

WellCare has been preparing for implementation of the Part D program for more than two years.

We are proud to be a partner with CMS in working to ensure that the program is meeting beneficiary needs and continues to be strengthened on an ongoing basis.

At every step of the implementation process, WellCare has provided leadership and offered input to CMS on measures needed to promote a smooth transition for beneficiaries. We have significantly expanded our customer service systems, we have reached out to pharmacists, and we have adopted transition policies to ensure that enrollees in our plans—including dual eligibles and low-income seniors—receive their medications on a timely basis.

Improvements to Customer Call Centers

In January, WellCare's call centers—like other PDPs across the nation—experienced extremely high call volumes. These call volumes were related to problems with eligibility data and operational difficulties in the pharmacies. Since our staffing models did not anticipate these problems and the calls they would create, we were not adequately staffed to absorb these additional calls. As a result, the performance of our call centers initially did not meet the high standards we set for our-

¹² AHIP, *Most Medicare Drug Enrollees Already Saving*, March 13, 2006.

¹³ AHIP, *Ninety Percent of Low-Income Seniors Surveyed Say No Problems Using Medicare Drug Benefit*, March 13, 2006.

selves. Most other plans had similar experiences. Therefore, we moved quickly in early January to adopt corrective measures, dramatically increasing our staff, working overtime, and refining our processes. Between January and April, we increased our staffing by approximately 75 percent.

Call volumes have moderated significantly as most of the eligibility and operational challenges have been resolved in the intervening months. Now, WellCare is consistently delivering service levels in excess of CMS requirements. In the month of April, WellCare answered 90 percent of our member calls and 87 percent of our pharmacist calls within 30 seconds. In March, those figures were 91 percent and 93 percent, respectively. Our average time to answer has been under 20 seconds over the last two months.

CMS has attempted to measure the performance of WellCare and other companies' call centers through an outside contractor. Unfortunately, this contractor's methodology appears to be flawed and is yielding results that are dramatically inconsistent with our data. We are working closely with CMS to urge improvements in the contractor's methodology. In the meantime, I am confident that the contractor's results, based on fewer than 80 calls per week, are less reliable than our data which is based on the thousands of calls we receive every week.

Transition to Formularies

To ensure continuity of care during the initial implementation of the program, WellCare and other plan sponsors adopted transition plans in January to ensure that beneficiaries continued to receive an initial prescription for covered Part D drugs they had been taking that otherwise would have been subject to formulary rules. CMS subsequently required all plans to extend these transition policies through a 90-day period that ended on March 31.

As we approached the end of this transition period, WellCare took a number of steps to ensure a smooth shift into the normal application of our formulary. First, we pro-actively communicated with members, pharmacists, and in some cases physicians to alert them to the fact that the transition would be ending soon and, additionally, to encourage a switch to formulary drugs. Second, we are phasing out the transition over several months to moderate the effect on members, providers and our own call centers. We have further increased our staff to be prepared to handle the requests for exceptions to our formularies in a timely manner. So far, we have succeeded in saving millions of dollars for members and taxpayers through the phasing in of our formularies, while at the same time maintaining call center times above CMS standards and continuing to respond to requests for exceptions to our formulary within 24 hours (versus the 72 hours required by CMS).

Simplifying the Exceptions Process

On April 11, AHIP and the American Medical Association (AMA) announced a standard form to simplify the process by which physicians can request prior authorization and coverage of non-formulary drugs under the Part D program. This standard form was developed through the collaborative efforts of plan sponsors, an AMA work group, and several beneficiary advocates. CMS is expecting Part D plans to implement the standard form as a "best practice" as soon as possible and will require its adoption in the near future. Meanwhile, AHIP members are continuing to work with the AMA and other partners on auxiliary forms that can be used for specialized drugs that require more information.

In addition to AHIP members and the AMA, other organizations involved in this collaboration include the American Psychiatric Association, the American Academy of Family Physicians, the American College of Physicians, the Medical Group Management Association, the National Council on the Aging, the Center for Medicare Advocacy, the Alzheimer's Association, the American Pharmacists Association, and the American Society of Consultant Pharmacists.

The agreement on this standard form is an important step toward ensuring that physicians know how to help beneficiaries obtain their medications on a timely basis. It also clearly demonstrates our industry's strong commitment to simplifying administrative procedures and improving uniformity wherever possible.

Standardizing Messages for Pharmacists

On April 18, AHIP joined the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists' Association (NCPA) in announcing a joint agreement on standardized electronic messaging that will promote the consistent use of key terms by Part D plans to assist pharmacists in better serving beneficiaries. The standardized electronic messages were developed to help pharmacists quickly determine the appropriate course of action for filling beneficiaries' prescriptions under four different circumstances: (1) when a particular drug is not covered; (2) when prior authorization is required; (3) when plan quantity or other

coverage limitations have been exceeded; and (4) when the pharmacy is not part of the Part D plan's network.

AHIP, the NACDS, and the NCPA have asked the National Council for Prescription Drug Programs (NCPDP) to endorse these messages at its upcoming meeting in May. The NCPDP previously adopted our recommendation to develop new codes for notifying pharmacists in clear, understandable terms when drugs are statutorily excluded from Part D basic benefits or are covered under Part B.

This agreement on standardized messaging is strengthening the program by helping to eliminate a possible source of confusion for pharmacists, thus allowing them to provide more prompt and effective service to beneficiaries.

Ensuring Continuity of Care

WellCare and other plan sponsors also have taken steps to balance the goals of: (1) ensuring continuity of prescription drug coverage for beneficiaries; and (2) using formulary management techniques to maximize the quality and cost-effectiveness of the Part D drug benefit. On April 27, AHIP's Board of Directors issued a statement (see Appendix A) indicating support for the principle of providing continuity of care for beneficiaries enrolled in the Medicare Part D prescription drug program. This statement supports recent efforts by CMS—announced by the agency in an April 26 guidance document—to ensure that Medicare beneficiaries who have been prescribed a medication on a Part D formulary will not be required to change their medication or pay increased copays or coinsurance throughout a contract year.

In addition to supporting continuity of care when formulary changes are made, the AHIP Board statement discusses the importance of providing Medicare beneficiaries with a prescription drug benefit that reflects the latest scientific evidence regarding the efficacy of various medication therapies, side effects and adverse reactions, interactions among medications, and disease-specific concerns. The statement identifies two circumstances under which formulary changes for existing enrollees are justified to protect the health of beneficiaries or enable them to receive greater value: (1) when safety or efficacy concerns have been identified by the Food and Drug Administration and/or the plan's Pharmacy and Therapeutics Committee based upon scientific evidence; or (2) when an FDA-approved generic alternative to a brand name drug becomes available.

AHIP's Board statement gives beneficiaries the peace of mind of knowing that they will be able to continue to receive their Part D formulary drugs throughout the year. At the same time, it preserves flexibility for plan formularies to maximize the value of the drug benefit when safety concerns are raised or generic equivalents come to market.

V. CONCLUSION

Thank you again for this opportunity to testify about our perspectives on these important issues. Please be assured that WellCare remains deeply committed to the long-term success of the Medicare Part D prescription drug program. We appreciate the support many Members of the Subcommittee have demonstrated for this valuable program and for a strong public-private partnership in Medicare. We look forward to continuing to work with you to meet future challenges in Medicare and throughout the U.S. health care system.

Appendix A

Statement by the Board of Directors, America's Health Insurance Plans on Maximizing Quality and Affordability of Prescription Drug Coverage for Medicare Beneficiaries

April 27, 2006

INTRODUCTION

Formularies and other pharmacy benefit management strategies allow Part D plans to control costs while ensuring the quality and safety of prescribed drugs for Medicare beneficiaries. These tools have kept Part D premiums affordable for beneficiaries and reduced costs to the Federal Government. Beneficiaries, who were initially expected to pay \$38 per month in Part D premiums, are paying an average of \$25. This is a savings of nearly one-third of the predicted premium amount, and the projected cost of the program to the Federal Government has been reduced by \$7.6 billion in 2006 and \$30 billion over the next five years. For this success to continue, Part D plans need to rely on the proven best practices in pharmacy benefit

management that are already providing Medicare beneficiaries with affordable, high-quality prescription drug benefits.

The formulary is a list of drugs that have been reviewed for safety and efficacy and are approved for coverage by the plan. Such drugs commonly are categorized into several "tiers," with cost-sharing for the drug determined by the tier to which it is assigned. Formularies play an integral role in ensuring beneficiaries have cost-effective access to clinically appropriate drugs. Part D plans have Pharmacy and Therapeutics (P&T) Committees, primarily composed of physicians and pharmacists that make decisions about which drugs to include on formularies based upon a clinical review of the scientific evidence. Formularies promote affordability by encouraging competition among pharmaceutical manufacturers. Once the P&T Committee determines there are multiple drug products with similar therapeutic value, they consider cost effectiveness to ensure that beneficiaries receive the greatest value from their prescription drug benefit.

The Centers for Medicare & Medicaid Services (CMS) evaluates and approves all Medicare Part D formularies to ensure they are comprehensive in accordance with CMS standards. CMS has established clear procedures under which beneficiaries and their physicians can request coverage of prescription drugs that are not on a plan's formulary. This process establishes strict timeframes and includes an opportunity to appeal to external reviewers who have no affiliation with the plan.

ENSURING CONTINUITY FOR BENEFICIARIES

In addition to premiums and out-of-pocket costs, the drugs included on a Part D plan's formulary and the tier structure are important factors that Medicare beneficiaries evaluate when determining which Part D plan best meets their specific needs and circumstances.

Appropriate formulary management improves clinical benefits and reduces costs for Medicare beneficiaries. The prescription drug arena is continuously evolving, with new scientific evidence emerging almost daily regarding the efficacy of various medication therapies, side effects and adverse reactions of both newer and older medications, interactions among medications, and disease specific concerns. With that in mind, Plan sponsors may need to make formulary changes during the year to provide Medicare beneficiaries with a prescription drug benefit that reflects the latest in scientific evidence.

At the same time, AHIP members strongly support maintaining continuity of care if a formulary change is made. Accordingly, we will support CMS' efforts to ensure that Medicare beneficiaries who have been prescribed a covered Part D formulary medication will not be required to change their medication or pay increased copayments or coinsurances throughout a contract year except when:

- Safety or efficacy concerns have been identified by the Food and Drug Administration and/or the plan's Pharmacy and Therapeutics (P&T) Committee based upon scientific evidence; or
- An FDA approved generic alternative to a brand name drug becomes available.

In these two circumstances, changes for existing enrollees are justified to protect the health of beneficiaries or enable them to receive greater value for the dollars they spend on prescription drugs while ensuring quality. Changes would only be made following appropriate notice as specified by CMS.

Chairman JOHNSON OF CONNECTICUT. Mr. Hays.

STATEMENT OF ROBERT M. HAYES, PRESIDENT, MEDICARE RIGHTS CENTER

Mr. HAYS. Good afternoon, Madam Chairman, Mr. Stark, Mr. Doggett. We do very much appreciate the opportunity to share with you our experiences and our clients' experiences during the first 4 months of the Medicare Part D implementation.

As you may know from national and State hotlines, casework, education programs, we provide direct assistance to people with Medicare. Each year the Medicare Rights Center receives over 80,000 calls for assistance. In recent months we have particularly

concentrated our services on enrolling people with Medicare in low-income programs, especially Extra Help.

We have also launched a Part D appeals program. We have recruited a battery of lawyers, volunteer lawyers and physicians, to assist people with Medicare, obtain the medications that plans have denied them.

The Medicare Rights Center is a nonprofit, independent organization relying on a small staff with hundreds of deeply committed volunteers. We are not supported by the pharmaceutical industry, the insurance industry, or any other special interest group. We have no political or commercial interest that interferes with our effort to propose public policies to serve people with Medicare.

That being said, Madam Chairman, at the Medicare Rights Center we are experiencing Part D to be badly designed, a scandalously wasteful program that provides far too little drug assistance, health security and peace of mind to people with Medicare.

Now, this does not mean that people with genuine need cannot and do not get meaningful assistance. We work to bring that help to people every day. We do not dispute the polls that say up to two out of three people enrolled in a plan are actually saving some money, but in a \$1.3 trillion program, we ask about the millions of people in need who are not seeing savings.

Our clients continue to report problems. Many find that their drugs are not covered by their plan, that they cannot afford their copayments, that they lost better coverage.

I will just mention very quickly some of the aid-specific correctives we are recommending in our written testimony.

Number one, first and foremost, Madam Chairman, we should automatically enroll eligible people in the low-income subsidy. There is widespread—there has been widespread bipartisan agreement that the number one priority of a Medicare drug benefit is to assist the poorest Americans, secure the medicines that doctors prescribe.

Our key work over the past 6 months has been to enroll as many people as we could in Extra Help. We have enlisted hundreds of volunteers to reach out. We advertise a toll-free phone number, run public service announcements, work cooperatively with drug plans. We work with pharmaceutical companies that supply us with contact information for poor people who have been disqualified from pharmaceutical assistance programs because of Part D. Ironically these people are good candidates for Extra Help.

Still the results are dismal. It takes 33 calls to identify a likely candidate for Extra Help; 80 percent of eligible people, Madam Chairman, have not yet been enrolled. These are the folks who need our help the most. We all admire the tenacity of Sisyphus futilely pushing his boulder up the hill, but that should not be our model in a public program aimed at protecting the lives of millions of Americans.

Federal financial data on income and income-generating assets can be used to automatically enroll men and women eligible for Extra Help. Automatic enrollment with opt out works very well in Medicare Part D, which has a 96 percent enrollment rate. It can work for part D's Extra Help as well.

Another recommendation, let us require meaningful Part D plan comparisons. Reasonable public policy should not require people with Medicare to shoot in the dark to pick a plan that will work for them. Thoughtful choices is not what has been going on over the past 3 or 4 months. Many callers now to a hotline, who are enrolled in plans, never understood that a covered drug could come with \$100 per prescription copayment. They never thought a covered drug would come with requirements that they try other medications first, or that their doctor would have to agree to become a witness in a legal appeal so they could get their covered drug.

Almost no one now hitting the gap in coverage, this infamous doughnut hole, was told about this by the plans. How many brokers, people earning commissions for each enrollment, each person they sign up, how many brokers do you think told their customers about the doughnut hole? Congress should force a more finite number of plans into meaningful comparisons to allow customers, however imperfectly, to make a less risky selection.

Look, even with these reforms, there still will be too much waste, not enough help to provide a benefit as good as we can afford with finite dollars. The lessons of Part D cry out for enactment of a drug benefit administered directly by Medicare. Let the plans compete with a Medicare drug benefit, increase choice, and look to keep administrative costs low and profiteering nonexistent. Honest supporters of a market approach should not fear competition, not even for Medicare.

Thank you.

[The prepared statement of Mr. Hayes follows:]

Prepared Statement of Robert M. Hayes, President, Medicare Rights Center

Good afternoon, Madam Chairman, Mr. Stark and Members of the Committee. We appreciate the opportunity to share with you our day-to-day experiences assisting people with Medicare obtain good health care. Today, we will report on the gratifying but often heart-breaking work we do with our clients as they struggle to navigate the Medicare Part D prescription drug program.

The Medicare Rights Center (MRC) is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities obtain good affordable health care. Every day we assist people with Medicare as they navigate the health care system, enroll in programs that can help them pay for health care, and overcome barriers to needed care.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent, relying on a small staff and hundreds of deeply committed volunteers to carry out our mission. We are not supported by the pharmaceutical industry, insurance companies or any other special interest group. Our non-partisan mission is to serve the 43 million men and women with Medicare.

Through national and state telephone hotlines, casework and professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. Each year, the Medicare Rights Center receives over 80,000 calls for assistance from people with Medicare. Our counselors are trained to assist consumers with complex problems and we complement the basic services offered by the 1-800-MEDICARE hotline operated by the Centers for Medicare and Medicaid Services (CMS). Indeed, 1-800-MEDICARE is the largest source of referrals to our hotline; MRC receives no CMS support for its consumer hotline.

MRC also brings to professional counselors, care givers and consumers across the country *Medicare Interactive*, a web-based counseling tool—developed with major foundation support and with a seed technology grant from the United States Department of Commerce. *Medicare Interactive* assists people with Medicare access benefits, including Part D.

We also reach out into low income, minority communities and, in recent months, have concentrated our services on enrolling people with Medicare in low income programs—the Part D Extra Help Program and Medicare Savings Programs, especially QI-1.

We have launched a Part D appeals program, recruiting a battery of volunteer lawyers and physicians to assist people with Medicare obtain medications denied to them by their Part D plans. Drug plans place the Medicare Rights Center's toll free phone number on notices informing their enrollees that the Part D plan is denying coverage of a prescribed medication. Since we receive no federal or state financial support to assist people with these Part D appeals, we can only make a dent in the great need for this assistance. The Committee should know that without competent, independent representation, the Part D appeals and exceptions process is, for most people with Medicare, a sham.

MRC gathers data on the health care needs of the men and women whom we serve, and devises policy recommendations from those data. MRC is committed to policy recommendations that are grounded in our work with the people we serve. We have the freedom of having no political or commercial interest that interferes with our efforts to propose sensible, non-ideological public policies that serve the interest of people with Medicare.

To that end, we reiterate our appreciation of this opportunity to share with you our experiences, our clients' experiences and the lessons learned from the first four months of the implementation of Medicare Part D.

“Scandalously Wasteful Program”

We intend to avoid the formulaic debates that Part D typically stimulates. As you may know, and as I will explain, we at the Medicare Rights Center consider Part D to be a badly designed, scandalously wasteful program that provides far too little drug assistance, health security and peace of mind to older and disabled Americans. The architects of Part D seem to have forgotten many of the lessons learned on what makes Medicare a national treasure.

But this does not mean that people with genuine need cannot and do not get meaningful assistance from the Part D drug benefit. We have no reason to dispute polls that say up to two of three people enrolled in a plan are saving at least some money. But in a \$1.3 trillion program, we must ask about the millions of people in need who do not see savings.

We have no reason to dispute, as the HMO lobby reported, that nearly 90 percent of the impoverished Americans switched from Medicaid drug coverage to Medicare drug coverage were not wrongly denied needed medication during the transition. But what about the ten percent, the 600,000 men and women—some small percentage of whom swamped our hotlines—that were?

People who have managed to enroll in the low income subsidy or Extra Help Program are certainly well served by Part D—so long as they find a plan that covers their drugs. But why have the diligent efforts of the Social Security Administration and hundreds of community organizations like MRC been able only to enroll less than 20 percent of eligible Americans in the Extra Help Program?

It is good news that millions of additional people with Medicare now have some drug coverage than had it in 2005. But millions do not and millions more are worse off than before.

Our clients come to us in droves to report continuing problems. Many find that their drugs are not covered by their plan, that they cannot afford their co-payments, that they lost better coverage. We believe that an objective appraisal of Part D would lead Congress to redesign this program, starting off by allowing Medicare to offer a drug benefit integrated into Part B that would be comprehensible and reliable.

But allow me to start with eight correctives that would make the existing drug program better able to meet its stated objectives.

AUTOMATICALLY ENROLL ELIGIBLE PEOPLE IN THE LOW INCOME SUBSIDY

Beatrice Gigi, an 87 year old resident of Queens, New York, receives a total monthly income of \$1,068 from Social Security and from a small pension from her union. She currently needs to fill two prescriptions a month, but has a hard time making ends meet. Her life savings are down to \$18,000, too much to qualify for the Extra Help Program, but too little to offer her peace of mind.

Since the beginning of the debate of the Medicare Modernization Act of 2003 (MMA), there has been widespread, bi-partisan agreement that the number one priority of a Medicare drug benefit is to assist the poorest Americans secure the medication their doctors prescribe. The low income subsidy, popularly called the Extra Help Program, offers the promise of a comprehensive and affordable drug benefit—so long as the patient selects a drug plan that works for her.

One of MRC's key priorities over the past six months has been to enroll as many people in that benefit as humanly possible. With funding from the Starr Foundation and Robin Hood Foundation, among others, we have enlisted hundreds of volunteers to reach out to likely candidates for Extra Help, explain the program to them and whenever possible enroll people on line. We are probably as sophisticated as anyone in conducting this work. We advertise a toll free phone number through AARP, chain drug stores, senior centers and elsewhere. We have public service announcements and look to work cooperatively with drug plans (who gain enhanced payments when we sign up their enrollees in Extra Help). We work with pharmaceutical companies that supply us with contact information for people with low incomes who have been disqualified from their patient assistance programs because of Part D: they are good prospects for Extra Help eligibility. Still, the results are dismal: it routinely takes 33 calls by MRC volunteers and staff to identify a likely candidate for the Extra Help Program.

We can all admire the tenacity of Sisyphus futilely pushing his boulder up the hill. But that does not mean that the *Myth of Sisyphus* should be our model in designing a public program aimed at protecting the lives and health of millions of older Americans. If we are sincere about assisting poor Americans with Medicare have real access to a comprehensive and affordable drug benefit, we know how to do it.

All people with Medicare whose financial data demonstrate eligibility for the low income subsidy should be automatically enrolled in the Extra Help Program. To simplify this, Congress should eliminate the asset test. The Social Security Administration's own figures show that the asset test disqualifies half those who apply for Extra Help. Considerable research—and MRC's on-the-ground experience—shows that the asset test discourages many people from even applying for assistance. But with or without an asset test, federal financial data on income and income generating assets can be used to automatically enroll men and women eligible for the Extra Help Program. Automatic enrollment, with opt-out, works well in Medicare Part B which has a 96 percent enrollment rate.

Congress: eliminate from the Extra Help Program these hoops that many frail elders will not be able to negotiate. Automatic enrollment could make real the promise of affordable medicine for many of the poorest Americans with Medicare.

REQUIRE MEANINGFUL PART D PLAN COMPARISONS

Reasonable public policy would not require people with Medicare to shoot in the dark to pick a drug plan that would work for them. We appreciate efforts like that of Congressman Doggett's daughter, a physician, to assist her grandmother select a drug plan. Secretary Leavitt, according to published reports, made a similar if less successful effort to assist his parents select a drug plan. But Las Vegas-style gambling on one's health care is not what we should be purchasing for our parents, our grandparents and ourselves.

Many callers to MRC's hotlines are among the more sophisticated of consumers. They did what the President and others told them to do. They found help with the internet, they found a plan that said it covered the drugs they now are taking, they found a plan with premiums and deductibles that seemed affordable, and they signed up.

Now they call us in a panic. They never understood that a "covered drug" could come with a \$100 per prescription co-payment. They never thought that a "covered drug" would come with trapdoors—requirements that they try other medications first, or that their doctor would have to agree to become a witness in a legal appeal so they could get the "covered drug." Almost no one now hitting the gap in coverage, the infamous donut hole, was told about this by the plans. How many brokers, people earning commissions for each person they enroll, do you think told their customers about the donut hole?

Melanie Kovarick, age 33 from Phoenix, Arizona is disabled because of multiple sclerosis and qualified for Medicare in March. She started researching prescription drug plans early on, but found the process to be more than difficult. She says, "There is a mind-numbing amount of research involved in trying to pick an appropriate plan. I read the entire 2005 Medicare changes book released in November. I read the entire 2006 Medicare options book released in December. Neither had any real details about what would or wouldn't be covered and the most in-depth comparison the whole program did was to determine which county each plan covered. I was referred to the State Health Insurance Program and the Medicare.gov web site and was promised they clearly answer any and all of my questions and help me perfectly plan the best options for my medical coverage.

"The Medicare.gov website was the worst disappointment, actually worse than the books that they published supposedly to educate us on the changes. There are roughly 40 options of different kinds of plans- all significantly different in how they pay and how YOU pay (monthly premiums, co-pays, co-insurance, and restrictions). You can try to use the benefit comparison tool, which only permits you to 'compare' three plans at a time and only provides the most BASIC of information on each plan.

"I keep looking and looking [at plans] but the options get worse and worse the more that I dig into them. These new 'plans' are a fragmented mess with every private company scrambling to get a new piece of this customer bonanza and all the Medicare recipients scrambling to try to catch the carrot dangling in front of them – help with rising prescription costs."

If a majority of the members of Congress continues to support this marketplace experiment, two steps could help: one, Congress should authorize a drug benefit integrated into Medicare to serve as a reliable safe harbor, a genuine choice, for people dissatisfied with the private plans; and two, Congress should force a more finite number of plans into meaningful comparisons that will allow, however imperfectly, some consumers to make a less risky selection.

END MARKETING ABUSES

MRC's experience with frantic callers to our hotline is leading us to the unhappy conclusion that nearly all marketing of Part D plans is misleading, nearly all of it exploitative of the neediest and frailest older Americans. Worst off are people who were contacted by telemarketers, a practice sanctioned by CMS. Caller after caller tell us that they did not know much about the plan they had enrolled in, and that they had been told things that were just not true. Other callers tell us that they did not know that they had signed up for an HMO, not a drug plan, until their doctor presented them with a bill and told them he is out of the HMO's "network." Increasingly, as people fall into the gap in coverage, the infamous "donut hole," they are shocked. Why?

Segundina Diaz is a 66-year-old woman from Queens, New York who has health insurance coverage through Medicare and New York Medicaid. Ms. Diaz met with the MRC counselors at her local senior center because she could not see her doctor with the Medicare Advantage HMO plan that she had signed up with. Her doctor was not in her plan's HMO network. Ms. Diaz told the MRC counselor that a marketing representative from a Healthfirst Medicare Advantage plan told her that she was going to lose her Medicaid coverage if she did not sign with this new plan. A caseworker at the senior center and the doctor's office tried to contact the market representative for days with no success. MRC finally contacted CMS and it authorized a retroactive disenrollment from the HMO.

The design of this privatized drug program creates a single commercial incentive for the drug plans, the brokers they employ, and the marketing firms they retain. The incentive: market share. Even putting aside purposeful fraud by the unscrupulous, deception is an inevitable by-product of this market created by the MMA and CMS.

Have you reviewed marketing material from the drug plans? Have you heard sales pitches at free breakfast meetings? At senior centers? A plan with a low deductible or a low premium will highlight that feature. People will be sold low deductible plans without understanding the other side: restricted formulary, rigid medication utilization tools, excessive costs per prescription. How many members of

Congress have seen plan marketing materials—TV ads, brochures, radio spots—talk about the gap in coverage? Even CMS is part of the problem. Late last year CMS spent untold public dollars running an insert about Part D in *Parade Magazine*. CMS, supposedly explaining the standard drug benefit, neglected to even mention the donut hole. Shareholders are protected by the Securities Exchange Commission and securities laws. Aren't older Americans entitled to similar protections from the predatory practices of the insurance industry? Deception comes in many forms: omitting material information from drug plan advertising is one that is epidemic in Part D.

Telemarketing of drug plans must be banned, and all marketing materials must be limited to accurate and comprehensive comparisons of standardized plans.

IMPROVE ACCESS TO MENTAL HEALTH DRUGS

Clients continue to flock to MRC seeking help with barriers drug plans are putting in the way of access to antidepressants and antipsychotics, drugs commonly needed by people with mental illnesses. As you know, CMS required plans to cover "all or substantially all" of these medicines, along with drugs in four other critical therapeutic classes. But that requirement is being undermined by other restrictions imposed by plans—prior authorization, step therapy and quantity limits. Quantity limits in particular are billed as "safety edits," but drug plans (seeking, of course, to maximize profits) generally impose them only on the most expensive drugs. Cost, not safety, is motivating the plans.

Mark McConathy, age 44 from Clearwater, Florida, is an engineer with a PhD in computer science. He designed data servers before a stroke left him unable to work. Now, Dr. McConathy takes 16 to 17 medicines a month, for various conditions including diabetes, hypertension and grand mal seizures, and is surviving on a monthly income of \$851. For his seizures, Dr. McConathy takes Clonazepam, a drug in the benzodiazepine family that is categorically excluded from coverage under Part D. At \$53 a month, Dr. McConathy has had to skip doses of Clonazepam leaving him more prone to grand mal seizures. Dr. McConathy has also had problems getting another mental health drug, Effexor, because his part D plan sponsored by AARP, imposes a quantity limit on it. Left with significantly higher drug expenses under Part D, Dr. McConathy is unable to afford both food and medicines.

One important, and relatively inexpensive, class of drugs—benzodiazepines—is excluded by law from Part D coverage. This exclusion threatens the stability of the drug regimens of many people with mental illness. Most state Medicaid programs continue to provide coverage but many people with low incomes do not qualify for Medicaid, and states are under financial pressure to cut back coverage. In Florida, people who qualify for Medicaid through spend down are finding it difficult to maintain access to these medicines.

Congress should end the exclusion of benzodiazepines from the Part D benefit and ensure adequate coverage of mental health drugs, and should enjoin plans from doing an end run around formulary requirements with utilization management dodges.

ELIMINATE THE "DONUT HOLE"

The donut hole, the gap in coverage that extends from about \$2,250 to \$5,100 in drug spending will disrupt treatment for needy men and women with Medicare. Our clients are hitting it already, and estimates suggest that some 7 to 10 million people with Medicare are at risk of reaching the coverage gap. Even those enrolled in a plan will be forced to choose between buying medicine, paying the monthly premiums they still owe, and buying other necessities of life. Most impacted are those who fail to qualify for the Extra Help Program, perhaps because a life insurance policy or other savings they rely on for financial security puts them over the limit.

Anthony Sakelarios, of Las Vegas, Nevada, is disabled due to severe degenerative disk disease that runs in his family. He has had two "failed" back operations and is in constant pain. On some days he is able to get to the food store or the pharmacy but he is usually unable to leave his home because he is in such pain. Mr. Sakelarios takes 10 medications – two of which are very expensive and help control the pain. Without warning, Mr. Sakelarios was just told that he had hit his drug plan's coverage gap and he would have to pay the full cost for his medications. He is over the limit for the Extra Help Program and is anxious about dipping into what is left of his saving to pay for his medications. He was told by his doctors that there is no surgical cure for his back problems and he will need to take medications for the rest of his life. Mr. Sakelarios worries about how he will be able to pay for his medications in the coverage gap next year, and the years after that – especially since he has learned that the gap will widen with each year.

We understand that the donut hole resulted from the financial constraints imposed on Congress by the White House when it was debating the MMA in 2003. But the decision to hand the drug benefit over to private insurers rather than have Medicare secure lower prices precluded savings that could have been used to fill the coverage gap. Studies show that, if Medicare secured the same prices that the Veterans Administration or other industrialized countries pay, there would be enough money to fill the donut hole. We appreciate that there is much debate, some of it informed, about this assertion. Proof of Medicare's effectiveness as a negotiator is found in the pharmaceutical industry's virulent opposition to allowing Medicare to negotiate drug prices.

We understand why PhARMA will fight this to the death. Why are a majority of the members of Congress afraid to try it?

STANDARDIZE, STREAMLINE PART D EXCEPTIONS AND APPEALS

Parts A and B of Medicare have worked well because they are based on the concept that individuals will have access to care deemed medically necessary by their treating physician. In theory, drugs under Part D are supposed to follow a comparable concept: while Part D consists of a patchwork of plans with various options and limitations on prescriptions, the MMA also includes exceptions and appeals provisions intended to allow individuals to access medically necessary drugs.

We now know from our first hand experience that the current system fails to deliver on this bedrock concept—access to medications that are medically necessary. Over the last several months MRC has helped hundreds of men and women take on the Part D appeals system. Most of our appellate clients had been denied access to medically necessary medications, and almost all were stymied by the Part D appeals process. Here are ways to improve this flawed, consumer hostile system:

- standardize the appeals process and forms;
- streamline the appeals process; and
- provide resources for independent consumer organizations to provide representation to people denied medically necessary medicine.

The Part D appeals process is impossible for the average consumer to navigate. Following near universal criticism, the recent move to standardize the coverage determination request form is a welcome, but very small start. Use of these forms by plans is voluntary, and they are only the first step in a multi-step appeals process. Steps must be taken to standardize the rest of the appeals process. There should be one form and one set of rules for obtaining an exception. That form and those rules should be posted on the CMS website and mailed to all people with Medicare. Obtaining life-saving medications should not be akin to navigating a mine-field.

Eric Lifschitz is a disabled New Yorker with Porphyria, a rare genetic condition. Medicaid had always covered Mr. Lifschitz's medications, including Anzemet and Protonix. Since early March, Mr. Lifschitz has been attempting to obtain medically-necessary quantities of his medications from his plan, First Health Premier. MRC has sent Mr. Lifschitz's case to the CMS regional office, but that office has been unable to help. His case has also been forwarded to the CMS Central office, but we have yet to receive a response. With MRC's help, Mr. Lifschitz filed a quantity limit exception request to First Health Premier on April 17th. Although all relevant time limits have expired, Mr. Lifschitz has not yet heard about whether or not this request has been granted. Due to his condition, Mr. Lifschitz is unable to tolerate alternative doses or medications.

A standardized appeals process must also be a streamlined one. Individuals should receive a formal denial before they leave their pharmacy, complete with plain instructions on how to appeal that denial. After an initial appeal to a Part D plan, individuals would then appeal directly to the Independent Review Entity.

This would cut out an unnecessary and generally futile step. Currently, after being denied a claim at the pharmacy, people with Medicare must ask the plan twice to cover their drug before receiving an independent review. Drugs subject to prior authorization require three requests for coverage at the plan level before an independent review is allowed. Each of these preliminary steps causes delay in violation of mandatory timelines and at considerable risk to the well being of the patient.

Further, for the current process to be meaningful, people with Medicare require assistance in prosecuting appeals. The current system assumes a helpful and willing physician. Do members of this Committee know many doctors who are routinely willing to take on arduous, uncompensated paper work for the sake of their patients? And who is to help patients pursue appeals?

As noted, MRC is listed on plan denial forms as a go-to patient advocate for people denied coverage of medicines prescribed by their doctors.

How much does CMS contribute to this representation?

Nothing.

How much do the drug plans contribute?

Less.

If Congress wants people with Medicare to have access to medically necessary drugs, it must standardize and streamline the Part D appeals process, and provide assistance to individuals with bona fide appeals of a plan's denial of medically necessary medications.

EXTEND THE MAY 15TH DEADLINE

It's difficult to believe that at some point in the next two weeks the Administration will not move to extend the May 15th deadline for enrolling in a Part D plan. From a bureaucratic perspective, we understand that the Administration believes that adding the pressure of a deadline on people will accelerate enrollment. From a humane perspective, adding more stress on people already overwhelmed with the anxiety of this complicated program will only add to more distress and more bad decisions. The May 15 deadline will lock in those bad decisions.

Connie Barron, age 65, lives in Stamford, Connecticut, and works part time as a social security benefits counselor with the STAR program. Prior to Part D, Ms. Barron had a patchwork of prescription drug coverage. She paid for some medicines out of her pocket and relied on free samples from her doctor for her most expensive prescriptions. Ms. Barron knew she wanted to sign up for a Part D plan, and she went about trying to learn more about the plans by looking on the Medicare.gov web site and calling several of the larger plans. Ms. Barron couldn't access the Medicare Plan Finder for help and when she called several of the plans she either couldn't get through or found the customer service representatives to be less than helpful. In the end, Ms. Barron chose her plan, AdvantraRx Premier Plus (at \$42.89 a month) because Coventry is based near her childhood home in Pittsburgh, Pennsylvania. When Ms. Barron called Coventry the operators were nice and she felt like she was "getting accurate and complete information." Upon reflection, Ms. Barron chose Coventry's because it felt familiar in a program that "lacks clarity" and is too complex. She hopes she has time to switch.

Although the deputy administrator at CMS has declared publicly that the agency lacks authority to extend the deadline, the Medicare Rights Center has supplied CMS with a legal analysis showing that it is amply empowered to create a special enrollment period that would cover this calendar year. This would allow people not yet enrolled in a drug plan to do so; perhaps more important, it also would allow people in the wrong plan to switch to one that works better for their health care needs. Justifications to create the special enrollment period are not hard to find.

Computer systems problems—blame CMS, blame SSA or blame the plans, they each blame each other—continue to leave people without coverage, enrolled in the wrong plan, or charged the wrong amounts for the plan that they are in. The insurer with the most Part D enrollees and the best brand name startled people with Medicare over the last two weeks by wrongly threatening to cut them off unless they promptly paid already paid premiums.

As noted, high-pressure marketers have steered people with Medicare into drug plans that do not cover their drugs and into HMOs that do not cover their doctors.

And no one, not even the strongest proponents of the drug program's design, anticipated that 40, 50 or even 60 plans would join the gold rush in most states leaving consumers bewildered and ripe for exploitation.

According to a *Washington Post* poll 71 percent of people polled support extending the enrollment deadline. According to a Kaiser Family Foundation poll, 45 percent of older adults say they do not know about the deadline. Fairness requires Congress to extend the deadline if the Administration refuses to exercise its power to do so.

DELAY THE ENROLLMENT PENALTY

Like the May 15th deadline, the prospect of a late enrollment penalty creates needless anxiety among people with Medicare already frustrated by a confusing choice of plans. The late enrollment penalty accrues during the months people with Medicare are locked out of drug coverage after May 15 and will rise each year as the average drug plan premium rises. With all the problems and confusion associated with the roll-out of the Part D benefit, it is inevitable that some people with Medicare will miss the enrollment deadline. Congress should step in and waive the late penalty for 2006.

People with Medicare below 135 percent of the federal poverty line pay only 20 percent of the late penalty for a limited period of time—literally just a few cents each month and less than the co-payments they are now struggling to pay. But for this vulnerable group, just the existence of a late penalty could discourage enrollment in the benefit. The administrative cost of collecting this penalty is not worth the revenue it generates. Congress should waive the late penalty for all low-income people with Medicare.

ENACT A MEDICARE DRUG BENEFIT

Gloria Tuttle, 78, and her husband Russ, 80, of Graham, Washington, have relied on Patient Assistance Programs for their 13 medications for chronic respiratory, cardiac and acid reflux conditions. These charity programs are a lifeline for Gloria and Russ who have a combined income of less than \$22,000 a year and cannot afford to spend hundreds of dollars every month on health care. The Tuttle's were informed that their Patient Assistance Programs would cut them off after May 15, so they sought out help. They consulted with SHIBA, Washington State's state health insurance assistance program, and learned that the cheapest plan for them would charge them \$30 for name-brand prescriptions and \$7 for generics with a \$51 a month premium.

The Tuttle's went straight to their doctor to switch as many of their prescriptions to generics as they could. With the changes, under the cheapest Part D plan, the Tuttle's co-payments would be nearly \$300 a month for all their medications, and an additional \$102 for the monthly premiums. When you add in their Medigap supplemental insurance premium, the total is far more than they could afford. So, the Tuttle's looked to government assistance programs for help. Unfortunately with a combined income of \$22,000, the Tuttle's make too much money to qualify for the Extra Help low-income subsidy program. But if they divorced, as single people they would each be under the income limit, \$14,700 a year, to qualify for Extra Help. The Tuttle's are seriously contemplating getting a divorce just to afford their medicines.

"I will not give up until I have tried everything I can – we have faith that the Lord will provide that help in some form and take care of our needs – and so we wait and pray," said Mrs. Tuttle.

These eight reforms would be helpful, because we believe in the principle that anything that helps a single person is a worthy reform. But, even with these reforms the drug benefit will continue to waste billions of dollars that could better be used to deliver a reliable and comprehensive drug benefit to people with Medicare through the Medicare program.

Americans need affordable prescription drug coverage that meets our changing health care needs, a program that covers the drugs we need today—and the drugs we will need tomorrow. Medicare provides a cost effective and largely affordable safety net, reliably allowing older and disabled Americans the peace of mind, the security of knowing that medically necessary and reasonable health care services will be covered. There is a human cost to abandoning that Medicare design for the coverage of prescription drugs.

To provide a benefit as good as we can afford with finite dollars, we think the lessons of Part D—objectively evaluated—teach that the Congress should enact:

- A drug benefit administered directly by Medicare, without the waste and restrictions that come with private health insurers as commercial, profit seeking middleman;
- Negotiated drug prices that keep costs down; and
- One comprehensible, reliable and secure drug benefit that adapts to the needs of the American people now and in the future.

Health security, not a health care lottery, is what people with Medicare require. People in good faith may still believe, even after the evidence of 2006, that the new cottage industry of for profit middlemen hawking incomprehensible drug benefit packages is the way to go. We do not think so. But we are content to allow those plans to continue, so long as these middlemen face a real market. Let the for-profit insurers compete with a Medicare drug benefit, one that fights for lower prices, and keeps administrative costs low and profiteering non-existent.

Honest supporters of a market approach cannot fear competition, not even from Medicare. There is nothing to fear but a better deal for people with Medicare and a fairer deal for the American taxpayer.

Chairman JOHNSON OF CONNECTICUT. Mr. Wolfe, do you think you could make it in 4 minutes, and we can take you. We still have to come back, and we will come back for questions.

Yes, why don't we come back. We will take the last two testimonies. This is a vote, two 5-minute votes, so it will be about 20 minutes. We will be back as soon as possible. Sorry about this.

[Recess.]

Chairman JOHNSON OF CONNECTICUT. The hearing will resume.

Mr. Wolfe, would you begin.

STATEMENT OF BILL WOLFE, VICE PRESIDENT, MANAGED CARE, RITE AID CORPORATION, HARRISBURG, PENNSYLVANIA

Mr. WOLFE. Good afternoon, Madam Chairman, Congressman Lewis and Congressman Camp. I am Bill Wolfe, president of Managed Care at Rite Aid Corporation, which is based in Camp Hill, Pennsylvania. I am pleased to be here today.

Rite Aid is one of the Nation's leading drugstore chains and is currently operating 3,300 stores in 27 States and the District of Columbia, with total sales of \$17.3 billion.

Rite Aid and the chain drug industry recognize that the implementation of Medicare Part D was a monumental task. Community pharmacists were clearly front and center once again, demonstrating their unique and very important position in the health care continuum as one of the most accessible and most trusted health care providers.

Given the scope of the program and some of the initial technological and data integrity failures, it is remarkable, in my opinion, how quickly the program stabilized. This would not have happened without the unprecedented cooperation of all stakeholders.

We appreciate the time that senior staff at CMS, as well as congressional staff and Members of Congress, spent recently visiting pharmacies, learning more about tremendous efforts made by community pharmacists to make this program work.

Rite Aid spent countless hours and made significant financial investment in systems and staff, preparing for Medicare Part D. We had an intense focus on educating and training our pharmacists. Our pharmacists and field management teams conducted thou-

sands of beneficiary outreach and educational sessions in their communities. Through our health plan partnerships, tens of thousands of beneficiary educational sessions were conducted in our stores, and we included messaging in our weekly ad circulars.

Through our preparation, pharmacists throughout the country were able to anticipate some of the implementation issues. While they struggled in the first few weeks of Part D, they always gave every effort to take care of their patients.

There are ongoing issues which we think can be corrected. First we will speak to the enrollment lag. If a beneficiary applies for the Part D benefit in the last few days of the month, an enrollment lag is created, and pharmacists don't have the necessary data necessary to fill a prescription. The best solution would be an enrollment deadline established each month so there is sufficient time to process applications and enter billing in the system.

We need to have standardized plan electronic messaging to pharmacies. Health plan messaging needs to be clear and provide actual information so pharmacists can promptly address a patient's needs. The National Association of Chain Drugstores, NCPA and AHIP have joined with CMS to help address this problem.

Formulary issues have begun to be addressed. Many beneficiaries are concerned that a plan could remove the drugs they are taking now from the Part D plan's formulary in the future. That is why we think that CMS's recent decision to allow a beneficiary to continue taking a formulary medication, even if the plan changes the formulary, is good for quality health care and will reduce administrative burdens.

I am concerned about the coverage gap. The concern is that Medicare beneficiaries do not fully understand the issues relating to the so-called doughnut hole and how it will affect their coverage. We believe that public-private sector collaboration to develop assistance programs for beneficiaries is imperative.

Community pharmacies are held to charging the beneficiary no more than their discounted contract rate and therefore contributes directly to assisting beneficiaries in the coverage gap. Many beneficiaries will undoubtedly need additional assistance to assure their access to needed medications.

We must also improve and reward quality. Improving quality under Part D by providing medication therapy management is important to everyone. Rite Aid has partnered with the University of Pittsburgh School of Pharmacy to offer medication therapy management services by specially trained Rite Aid pharmacists.

We welcome the formation of the Pharmacy Quality Alliance, which CMS has indicated could lead to new pharmacy payment models based on optimizing the patient outcomes. Rite Aid supports efforts on controlling costs by paying for better care and improved outcomes, not by reducing payment rates to providers.

While Medicaid is not in the Committee's jurisdiction, I feel compelled to raise concerns about changes to the Medicaid program as part of the Deficit Reduction Act, which will substantially impact community pharmacies' ability to serve Medicare as well as Medicaid patients.

The DRA reduces payments to pharmacies for generic medications under Medicaid by about \$6.3 billion over the next 4 years.

We believe that the reduction in payment will take away much of the incentive for pharmacists to dispense generic medications. This is baffling, given that most States spend less than 25 percent of their Medicaid pharmacy fund on generics, even though generics are more than 50 percent of the prescription volume.

Public and private payers should be doing everything they can to increase, not decrease, the dispensing of generic drugs. Generic drug utilization is one of the most cost-effective ways to control prescription drug costs.

Reductions of this magnitude in Medicaid, coupled with the current economic impact of the Medicare Part D program, will unquestionably reduce access to pharmacies. Retail pharmacy is an extremely competitive, low-margin industry operating on an average profit margin of 2 percent. We hope that you will support the delay or revision of these Medicaid pharmacy payment changes as the industry adjusts to the operational and economic challenges of Medicare Part D.

Thank you very much for this opportunity to share Rite Aid's perspective. We will look forward to continuing to work with Congress and the Administration on these issue. I will be happy to answer any of your questions at the conclusion.

Chairman JOHNSON OF CONNECTICUT. Thank you very much.

[The prepared statement of Mr. Wolfe follows:]

Prepared Statement of Bill Wolfe, Vice President, Managed Care, Rite Aid Corporation, Harrisburg, Pennsylvania

Good afternoon Chairwoman Johnson, Ranking Member Stark, and Members of the Ways & Means Health Subcommittee. I am Bill Wolfe, Vice President of Managed Care at Rite Aid Corporation, which is based in Camp Hill, PA. I am pleased and honored to be here today to participate in this important hearing on implementation of the Medicare Part D prescription drug benefit program.

Rite Aid Corporation is one of the nation's leading drugstore chains, combining its modern store base, strong brand name, modern distribution centers and superior pharmacy technology with a talented team of approximately 70,000 full and part-time associates serving customers in 27 states and the District of Columbia. Rite Aid currently operates approximately 3,320 stores, reporting total sales of \$17.3 billion at the end of its 2006 fiscal year.

Preparing for the Medicare Part D Benefit

Rite Aid and the chain drug industry recognize that the implementation of Medicare Part D was a monumental task and represented the most significant expansion of Medicare since its inception. We are pleased and proud to have played a key role in assuring that millions of additional seniors now have access to prescription drug coverage as a result of the Part D benefit. Community pharmacists were clearly front and center and once again demonstrated their unique and very important position in the health care continuum as one of the most accessible and trusted health care providers.

As has been widely reported, there have been challenges for both beneficiaries and pharmacists in transitioning to Part D, particularly in the first few weeks of the program. We have all heard about the long wait times that many beneficiaries had at their local pharmacy, and about the lengthy periods pharmacists spent on hold with CMS and health plans, trying to get the information they needed to dispense prescriptions to their patients. Rather than rehashing the difficulties that were experienced, most of which have improved exponentially, I'd like to spend my time before the subcommittee discussing the steps Rite Aid took to prepare for Medicare Part D, review the actions taken by CMS, pharmacies, and plans to address some of the challenges that were faced, and to provide Rite Aid's thoughts on how we can continue to work together to improve the Medicare prescription drug benefit moving forward.

Rite Aid and the rest of the chain drug industry appreciate the efforts of CMS, states, and health plans in working collaboratively to quickly address many of the initial implementation issues. Given the scope of the program and some of the initial technological and data integrity failures, it is remarkable in my opinion how quickly the program stabilized. This would not have happened without the unprecedented cooperation of all stakeholders. For example, CMS, pharmacies, and health plans worked together to create the “TrOOP facilitator,” a tool that allows pharmacies to electronically query a special database and instantaneously obtain information about the Part D plan in which a Medicare beneficiary has been enrolled, including the beneficiary’s billing information. Ideally, the TrOOP facilitator also assists with the coordination of benefits with other payers. While there have been some ongoing issues with incomplete and inaccurate data, we hope that the TrOOP facilitator process will serve as a model for how the public and private sectors should work together to address future Medicare Part D issues. We must continue to work together to assure continued improvement in the process as well as data integrity, so that as the May 15 deadline approaches, or when we face other time periods with peak enrollment, we do not experience the same difficulties that we all faced in January of this year.

We also appreciate the time that senior staff at CMS, as well as congressional staff and Members of Congress, spent in the last several months visiting pharmacies and learning more about the tremendous efforts made by community pharmacists to make this program work. I personally toured stores with the Region 3 HHS Regional Director from Philadelphia so he could interview pharmacists and observe their interaction with Medicare beneficiaries. I am proud of all that Rite Aid pharmacists—and other community pharmacists—have done to make sure that Medicare beneficiaries receive their prescriptions in a timely manner.

Rite Aid spent countless hours and made significant financial investments preparing for Medicare Part D. We focused on educating and training our pharmacists, starting with weekly messages and information bulletins in April of last year. In addition, we had a chain-wide, computer-based training (CBT) on Medicare Part D that was mandatory for our pharmacists, and I’m happy to say that it achieved the fastest uptake of any CBT ever conducted at Rite Aid.

Our pharmacists and field management teams conducted thousands of outreach sessions in malls, senior centers, and places of worship with education materials that we created with the help of our supplier and health plan partners. Through our health plan partnerships, tens of thousands of educational sessions were conducted in our stores, and we included messaging that encouraged beneficiaries to seek out information and sign up in our circulars, which have a weekly circulation of fifty million.

In addition to the many hours that our pharmacists and other employees spent in preparation for Part D implementation, Rite Aid also invested in system upgrades to accommodate TrOOP facilitation and coordination of benefits billing. We also installed a new state of the art telecommunication system and doubled the staff in our pharmacy help desk area in anticipation of Medicare Part D implementation.

Through this preparation, Rite Aid pharmacists, as well as other chain drug pharmacists throughout the country, were able to anticipate some of the issues. While they struggled in the first few weeks of Part D, they always gave every effort to take care of their patients. In many cases, this meant providing needed medications without any assurance of compensation. As I’ve stated, thankfully many of the issues have stabilized and have been resolved. However, there are ongoing issues that we think can be corrected to continue to ease the administrative burden placed on pharmacists and to facilitate beneficiary access to their medications.

Rite Aid has several suggestions on how some of the ongoing implementation issues can be addressed:

Addressing Part D Issues Moving Forward

Fix Enrollment Lag: Individuals become eligible for Medicare every day, and dual eligibles have the option of changing plans every month. As a result, there is a systematic issue, commonly referred to as the “enrollment lag,” that is problematic for pharmacies and beneficiaries.

Currently, a Medicare beneficiary can enroll in a Part D plan at any time and expect their enrollment to be effective the first day of the following month. If a beneficiary applies for the Part D benefit in the last few days of the month, it is simply not possible for CMS and the plans to process the beneficiary’s application, confirm eligibility with CMS, and provide the necessary billing information to the TrOOP facilitator so that it is available to pharmacists in time for the beneficiary to receive their prescriptions the first day of the next month.

Unless policymakers address this “enrollment lag” issue, late-month enrollment or plan switches may continue to be the single most challenging issue that beneficiaries and pharmacists face with Part D. If pharmacists don’t have the necessary data, they cannot fill a prescription. This takes pharmacists away from serving their patients, and forces a series of calls to CMS and health plans to obtain billing and enrollment information. Pharmacists and other pharmacy staff find this experience very frustrating, but even more importantly, so do Medicare beneficiaries, who are forced to wait for extended periods of time at the pharmacy or return at a later date to obtain their prescriptions.

A variety of options exist to address this issue, and Rite Aid and the chain drug industry are committed to working with CMS and health plans to find the best solution. CMS is trying to address this issue by educating beneficiaries that enrolling late in the month will result in delays in activation of prescription drug coverage. This is a step in the right direction. Optimally, there should be an enrollment deadline established each month so there is sufficient time to process applications and enter the billing information in the system. We urge policymakers to address this issue soon.

Standardized Plan Messaging: Virtually 100% of all prescription claims are processed electronically, making pharmacy claims processing far more efficient than any other segment of health care. These efficiencies result in faster service to our customers, accuracy in our claims processing, and cost savings to the entire prescription drug delivery system.

Despite this efficiency, lack of standardization in messaging to pharmacists among third party payers still results in pharmacists spending much of their time on administrative issues. These third party prescription administrative issues and the time that pharmacists must devote to them have multiplied significantly since the onset of Part D.

Dozens of new Part D plans each have their own policies, processes, and procedures for pharmacists to follow in order to fill prescriptions. Some Part D plans want pharmacists to fax forms to physicians when they need prior authorization to fill a prescription, while other plans require the pharmacist to call the plan’s help desk. Furthermore, even when plans choose the same method of communication, the message is not always clear. Merely telling a pharmacist that a drug is “not covered” does not give pharmacists the information they need. Health plan messaging needs to be clear and provide actionable information so pharmacists can promptly address a patient’s needs.

Once again, the pharmacy community is not just talking about the need, we’re taking action. I’m pleased to report on another public-private partnership to improve the Medicare prescription drug benefit. The National Association of Chain Drug Stores (NACDS), National Community Pharmacists Association (NCPA), and America’s Health Insurance Plans (AHIP) have joined with CMS to help address this problem.

Working together, these groups have started down the road of developing uniform, standardized messages that will be sent electronically to pharmacists when a prescription drug claim is rejected. This will provide more information to the pharmacist on why there might be an issue or problem with the prescription, as well as help the pharmacist understand what to do next. The goal is to reduce phone calls from pharmacists to health plans, allowing them to spend more time with their patients. Rite Aid commends the leadership of CMS and these associations for addressing this problem, and looks forward to working with them on this and other issues to improve the Part D benefit. We hope that this will serve as the first step in a broader effort to promote more standardization in third party prescription claims processing, pharmacy messaging, and procedures that would benefit all public and private prescription drug programs.

Formulary Issues: There have been some difficulties for both beneficiaries and pharmacists with understanding Part D drug formularies and how they work. Many beneficiaries that come into our pharmacies are concerned that in the future a plan could remove the drugs they are taking from the Part D plan’s formulary. Our pharmacists are also concerned about the quality of care impact of switching beneficiaries from a medication they have been taking for a long time to a different medication. There are also concerns about whether beneficiaries—especially low income dual eligibles—will be able to navigate the exceptions and appeals process. That is why we think that CMS’ recent decision to allow a beneficiary to continue taking a formulary medication—even if the plan changes the formulary—is good for quality health care and will reduce the administrative burdens on beneficiaries, physicians and pharmacists to switch medications for Medicare beneficiaries.

Coverage Gaps: We are rapidly approaching the middle of the year when many seniors may fall into the “donut hole” or coverage gap. We are concerned that many

Medicare beneficiaries do not fully understand the issues relating to the “donut hole” and how it will affect their Medicare coverage. Many of our pharmacists are concerned that they will bear the brunt of beneficiary frustrations when they find out that they are still paying premiums while in the “donut hole,” but not receiving any coverage for their prescription medications.

We also believe that another public-private sector collaboration to develop assistance programs for beneficiaries when they hit the coverage gap would go a long way toward improvement of the program. Community pharmacy is held to charging the beneficiary no more than their discounted contract rate and therefore contributes directly to assisting beneficiaries in the coverage gap. However, many beneficiaries will undoubtedly need additional assistance to assure their access to needed medications, so we believe that other parts of the system should step forward and do their part as well.

Improve and Reward Quality: Improving quality in health care by providing chronic care management, disease management and medication therapy management programs is important to Rite Aid. We know that Chairwoman Johnson and the Members of the Subcommittee recognize the value of these programs in improving our health care system as well. At Rite Aid, we have focused on these issues by partnering with the University of Pittsburgh’s school of pharmacy to offer medication therapy management services by specially trained Rite Aid pharmacists. These pharmacists work with patients to ensure that each is on the most effective drug therapy to meet therapeutic goals and avoid medication-related side effects. Pharmacists share results with each patient’s physician to ensure continuity of care. While this program is currently centered in the Pittsburgh region, we have designed it to be scalable and hope to continue to expand it throughout the country.

We believe that medication therapy management services like these result in healthier patients. They also reduce health care costs for payers, and go hand in hand with other ongoing efforts by pharmacists to control health care expenditures, such as encouraging the use of lower-cost generic drugs. That’s why we welcome the recent announcement by CMS Administrator McClellan on the formation of the Pharmacy Quality Alliance (PQA), a collaborative effort among the pharmacy community, health plans, employers, government payers, and others to improve health care quality. In addition to developing strategies to define and measure pharmacy performance, CMS has indicated that PQA could also lead to new pharmacy payment models based on optimizing patient outcomes. Rite Aid supports efforts that focus on controlling costs by paying for better care and improved outcomes, and not by reducing payment rates to providers.

Impact of the Deficit Reduction Act on Medicare

Community pharmacy has shouldered much of the economic and administrative burden of implementing the Medicare Part D benefit. We believe that we have been an important part of the rapid correction and stabilization of the program. While Rite Aid and other pharmacies across the country are still making adjustments as a result of Part D, we will again be asked to shoulder an incredible burden only one year later when drastic changes to the Medicaid program are implemented. While Medicaid is not in this subcommittee’s jurisdiction, I feel compelled to raise concerns, as the changes to the Medicaid program as part of the Deficit Reduction Act (DRA) will dramatically impact community pharmacy’s ability to serve Medicare, as well as Medicaid, patients.

The DRA reduces payments to pharmacies for generic medications by about \$6.3 billion over the next four years. Beginning January 1, 2007, federal upper limits (FUL) for generic drugs will be based on Average Manufacturers Price (AMP), rather than Average Wholesale Price (AWP). We believe that the reduction in payment will be so severe that it will take away much of the incentive for pharmacists to dispense generic medications. This is baffling, given that less than 25% of the average state’s Medicaid pharmacy payments are for generics, even though generics are more than 50% of the prescription volume. Public and private payers should be doing everything they can to increase, not decrease, the dispensing of generic drugs, since generic drug utilization is one of the most effective ways to control prescription drug costs.

The Deficit Reduction Act also requires CMS to make Average Manufacturers Price data available to states and the public beginning in July—only two months from now. In theory, AMP reflects the average prices paid to manufacturers by wholesalers for drugs distributed to the retail class of trade, which include retail pharmacies. However, we are very concerned that since there are no guidelines as to how manufacturers should calculate AMP, the AMP data released by CMS this July will be inaccurate and will not reflect the actual prices that retail pharmacy pays for brand and generic medications. As a result, states, Medicare plans, and

consumers could receive a misleading picture about the true acquisition costs of retail pharmacies. Medicare plans and other payers could conceivably change their pharmacy reimbursement based on faulty AMP data.

This data will be publicly available for one full year before CMS is required to issue a rule instructing prescription drug manufacturers on how to calculate AMP. Because of its potential damaging impact to community pharmacy, we believe that this data should not be made public or shared with the states until AMP is accurately and consistently defined.

Reductions of this magnitude in Medicaid, coupled with the current economic impact of the Medicare Part D program, will unquestionably reduce access to pharmacies. Retail pharmacy is an extremely competitive, low margin industry, operating on an average profit margin of two percent. We do not believe that policymakers have taken into account the cumulative economic impact that changes to Medicare and Medicaid will have on retail pharmacies and the communities they serve. We hope that you will support the delay or revision of these Medicaid pharmacy payment changes, as well as the public release of these inaccurate data, as the industry adjusts to the operational and economic challenges of Medicare Part D.

Conclusion

Thank you again for this opportunity to share Rite Aid's perspective on the implementation of the Medicare Part D benefit. We look forward to continuing to work with Congress and the Administration on these issues. I would be happy to answer any questions. Thank you.

Chairman JOHNSON OF CONNECTICUT. Ms. Grisnik.

STATEMENT OF PAM GRISNIK, OWNER, RX EXPRESS, GROVE CITY, PENNSYLVANIA

Ms. GRISNIK. Good evening, Madam Chair and other Members of the Subcommittee on Health. Thank you for conducting this hearing and providing me the opportunity to share the experiences with the new Medicare Part D program on behalf of the NCPA. The NCPA represents more than 24,000 community pharmacies, 55,000 community pharmacists, 250,000 employees and millions of patients who rely on us for their prescription care. The Nation's independent pharmacies dispense nearly half of the Nation's retail prescriptions.

Independent pharmacists provide vital prescription services in both rural and urban areas, where many patients could not receive their prescription drugs were it not for their neighborhood pharmacy and the relationships they have developed with their local pharmacist.

My name is Pamela Grisnik, and I am from Grove City, Pennsylvania. Sitting behind me is my husband Paul. We have both been pharmacists for 24 years, the last 16 which we have owned the RX Express Pharmacy in Grove City. We were also members of the NCPA, the International Academy of Compounding Pharmacists, and the Pennsylvania Pharmacists Association, of which my husband Paul is on the executive council. We currently employ 16 full-time staff people who provide personalized care for approximately 12,000 patients in our community. We were also sponsors for five pharmacy interns from three different schools of pharmacy in western Pennsylvania.

We have built our practice in the face of numerous competitors by focusing on patient care. Our patients' health is our main concern.

The change I have seen in my practice since the start of Medicare Part D can be summarized as follows. First, Part D reimbursements are too low and too slow.

Secondly, unfortunately, the confusion around Part D continues. The State previously reimbursed my pharmacy on a weekly basis for prescriptions I filled for dual-eligibles. We are currently waiting a minimum of 4 to 5 weeks for reimbursement on these same prescriptions. Reimbursements are simply too slow.

This past weekend I caught a drug interaction for a Part D patient. After 45 minutes of my time, consulting with a doctor and the patient, I finally was able to correctly fill the prescription for this patient. I was unable to submit the claim for the payment as the plan's computer system was down. Once the claim finally was submitted, I discovered my total reimbursement was \$2, period, \$2. That is it. Not even a hamburger, \$2; \$2 to cover the medicine, the bottle, the label, my technician, the rent, the utilities, not to mention the pharmacist's time and the counseling. This reimbursement is simply too low.

Thirty-six percent of independent pharmacy owners are afraid that low and slow reimbursements will put them out of business; 29 percent have asked their wholesaler for assistance; 29 percent have taken out a line of credit. Cash flow is worse for 93 percent of independents who are waiting on an average of 70,000 in reimbursements from each Part D plan. Low and slow reimbursements are a very, very real problem.

Secondly, the confusion of Medicare Part D does continue. Many patients are already hitting the doughnut hole. They do not understand the doughnut hole. Many pick up their prescriptions. They leave. This has happened many times the past couple of weeks. They come back. They throw their bag at me and say, you made a big mistake. I paid \$20; this is \$160 or \$100. You have made a huge mistake, Pam. You better check your records.

I try to explain the doughnut hole to them. They look a little confused. Somehow they maybe remember. I usually call the plan so they can actually hear from the representative from their plan the bad news from the plan directly that this is the doughnut hole, how much they have spent, how much more they need to spend to get out of it. None of them really did expect this yet, and few can afford the higher costs. The sudden changes have confused the seniors, and the confusion continues.

Those who have not signed up are nervously eyeing the May 15 deadline. Many have tried to navigate their array of choices and have really, truly been discouraged by the complexity of the benefit. They do come into the pharmacy. They do throw stacks of paper at me and say, please, Pam, Paul, will you please help me go through this? Will you help me sign up? They have been to seminars. They have been to many seminars. Some of them are still very, very confused.

We are in a college town. One of our patients is a retired college professor. She came in to me with her Part D papers and said, I have a doctorate. I thought I was intelligent. Obviously I am not.

The Medicare Part D benefit card should not be an advertising space, yet some Part D benefit cards have the featured logos of national chain pharmacies and retailers. Many of my patients do not

realize that they can still continue to come to my pharmacy. They look at the card that has the advertisement. They go to that pharmacy.

Some patients have returned to my pharmacy, but the confusion does continue. Sometimes when they call the third party, the Medicare program. They don't tell them that I am part of the plan even though I am.

Many of the community pharmacies' concerns concerning Part D are addressed by the Jones-Berry bill, H.R. 5182. This bill does clarify the rules on cobranding, requires prompt payment for properly submitted claims, and establishes a minimum reimbursement on generic drugs. Chairman Cochran has also introduced a similar bill in the Senate. These commonsense improvements will ensure that Medicare Part D will deliver its full promise for our seniors.

Some 15 years ago I myself was diagnosed with leukemia and told I had a month to live. From that experience and from my professional work, I do understand the importance of having access to quality prescription care.

My fellow community pharmacists and I are looking forward to working together with you to solve these current issues and would like to ask for your help so that we can continue to provide quality prescription care to our patients.

Thank you for inviting me to speak on this important issue. I will be happy to answer any questions you may have.

[The prepared statement of Ms. Grisnik follows:]

**Prepared Statement of Pam Grisnik, Owner, RX Express, Grove City,
Pennsylvania**

Good Afternoon, Madam Chair and other members of the Health subcommittee. Thank you for conducting this hearing and for providing me the opportunity to share the experiences with the new Medicare Part D program on behalf of the more than 24,000 community pharmacies, 55,000 community pharmacists, 250,000 employees and the millions of patients who rely on us for their prescription care.

My name is Pamela Grisnik of Grove City, Pennsylvania. Sitting behind me is my husband, Paul. We've both have been pharmacists for 24 years, the last 16 of which we have owned the Rx Xpress Pharmacy in Grove City. We are members of National Community Pharmacists Association, International Academy of Compounding Pharmacists and the Pennsylvania Pharmacists Association, of which Paul is on the Executive Council.

I am honored to testify today to give you the perspective of independent, community pharmacy on Medicare Part D and to testify on behalf of the National Community Pharmacist Association. NCPA represents the nation's community pharmacists, including the owners of more than 24,000 pharmacies, 55,000 pharmacists and over 250,000 employees. The nation's independent pharmacies dispense nearly half of the nation's retail prescription medicines. Independent pharmacists provide vital prescription services in both rural and urban areas, where many patients could not receive prescription drugs were it not for their neighborhood pharmacy and the relationships they have developed with their local pharmacist.

Most pharmacists have three years of post-baccalaureate education and we have extensive continuing education requirements. We consider ourselves to be both health care professionals and small businessmen and women. We take great pride in helping patients. When I decided to go into this profession, my thinking was not, "what kind of small business can I own?" Rather, I found a calling in helping patients with their vital prescription needs—my decision to own a small business came later. So my perspective in speaking to you today is not to talk about Part D as a businessperson, but as a health care provider who is concerned about my ability to continue to provide vital health services in my community.

We currently employ 16 full-time staff people who provide personalized care for approximately 12,000 patients in our community. We are also preceptors for 5 pharmacy interns from three different schools of pharmacy in Western Pennsylvania.

We have built our practice in the face of numerous competitors by focusing on patient care. Our patient's health is our main concern.

The change I've seen in my practice since the start of Medicare Part D can be summarized as follows: First, Part D reimbursements are **too low** and **too slow**. Secondly, the confusion surrounding Part D continues.

The state previously reimbursed my pharmacy on a weekly basis for prescriptions I filled for dual-eligible patients. We are currently waiting a minimum 4 to 5 weeks for reimbursement on these same prescriptions. Reimbursements are **simply too slow**.

This past weekend I caught a drug interaction for a Part D patient. After 45 minutes consulting with the doctor and patient I was finally able to fill the correct prescription for the patient. I was unable to submit the claim for payment as the plan's computer system was down. Once the claim was submitted, I discovered my total reimbursement was two dollars, period. Two dollars to cover the *medicine*, the *bottle*, the *label*, my *technician*, the *rent* and the *utilities*, not to mention the pharmacist's time and counseling. This reimbursement is simply too low.

36% of independent pharmacy owners are afraid that low and slow reimbursements will put them out of business. 29% have asked their wholesaler for assistance, and 29% have taken out a line of credit. Cash flow is worse for 93% of independents, who are waiting for an average of \$70,000 in reimbursements from **EACH** Part D Plan. Low and Slow reimbursements are a very real problem.

Secondly, the *confusion* of Medicare Part D *continues*. Many patients are already hitting the donut hole. They don't understand what has happened. Many will pick up their prescriptions, leave, and come back to the pharmacy thinking that I did not charge them correctly. "Last month my pills were \$20, now they're \$100 . . . What happened?" After explaining the donut hole, I usually call the plan so patients can hear the bad news from the plan directly. None of them expected this yet, and few can afford the much higher costs. The sudden changes have confused seniors. The confusion continues.

Those who have not yet signed up are nervously eyeing the May 15th deadline. Many have tried to navigate the array of choices and have been discouraged by the complexity of the benefit. They come into the pharmacy, throw us a stack of papers in desperation saying, "Please, can you and Paul please help me, tell me what to do."

We are a college town, one of our patients is a retired college professor. She came to the pharmacy with her Part D papers and declared, "I have a doctorate. I thought I was intelligent, but I obviously am not."

The Medicare Part D benefit card should not be an advertising space. Yet some Part D benefit cards have featured the logos of national chain pharmacies and retailers. Many of my patients did not realize they could continue coming to my pharmacy. Some of my patients believed they could only patronize those pharmacies featured on the benefit card. Some patients have returned to my pharmacy, but again the confusion continues.

Many of community pharmacy's concerns regarding Part D are addressed by the Jones-Berry bill, H.R. 5182. This bill clarifies rules on co-branding, requires prompt-payment for properly submitted claims, and establishes a minimum reimbursement on Generic drugs. Chairman Cochran has also introduced a similar bill in the Senate. These common-sense improvements will ensure that Medicare Part D will deliver its full promise for our Seniors.

Some 15 years ago I was diagnosed with leukemia and was told I had a month to live. Both from that experience and from my professional work I do understand the importance of having access to quality prescription care.

My fellow community pharmacists and I are looking forward to working together with you to solve these current issues and would like to ask for your help so that we can continue to provide quality prescription care to our patients. Thank you for inviting me to speak on this very important issue and will be happy to answer any questions you may have.

Neither I nor my husband, nor community pharmacists and NCPA, wish to give you a litany of complaints. Pharmacists and NCPA have never opposed the goal of Medicare Part D: providing prescription drug services to some patients that otherwise would not be able to acquire them. Others on these panels have already spoken regarding the degree to which that goal has been achieved. We know that this program has been working for some. There has also been some progress on implementing Part D, such as a reduction in the long wait times on our calls to CMS.

II. Problems with Part D

I would be doing you and the Program disservice, however, if I did not address the continuing, systematic problems with Part D that threaten to negate what is working with the program, and what were designed to be cost-saving aspects of the program. A legislative fix is needed, and one particular one, the Jones-Berry FAST Act, fixes some of the on-going problems.

In sum, those problems are: (1) delays in reimbursements hurting the ability of pharmacists to keep their doors open and provide services; (2) not getting adequate payments that reflect the costs of dispensing drugs, thus creating a perverse incentive to dispense brand name drugs; and (3) continued co-branding, which confuses seniors and other Medicare recipients into thinking they have to stick with the companies printed on the benefit cards.

A. Closures Caused by Implementation Hurt Patients and Communities

Independent pharmacists have been the backbone of the delivery system for Medicare Part D. In fact, they have saved the program by bearing its financial and bureaucratic burdens. Secretary Leavitt has been quoted as saying that “no patient should leave the pharmacy without their prescription.” Unfortunately, that has happened to me in certain cases where the patient has been unable to wait while I am on hold with CMS while getting authorizations. Some patients have handed back filled prescriptions in anger and walked out of our pharmacy. When patients do leave my pharmacy without a prescription, it is not because of the pharmacists. Pharmacists pay for the drugs they dispense, and then often wait months for reimbursement by the prescription drug plans—despite the fact that the PDPs are paid in advance for the drugs, and then they sit on processing the claims. Pharmacists are acting as private banks to these plans while the plans hold onto government money—that is to say, taxpayer dollars.

Because of the reimbursement flow problem, since the implementation of Part D began in January of this year, some one dozen independent pharmacies have already had to shut their doors. In rural areas, these closures have a truly harmful effect on the health care of Americans dependent on Medicare—particularly the elderly. Because it addresses this problem and the problem of adequate dispensing fees, we and NCPA support the bipartisan Jones-Berry FAST bill.

In response to a NCPA survey on Medicare Part D conducted just a couple of weeks ago:

1. Over half of the respondents (53%) serve a population of less than 20,000 people; and
2. Over 99% of the respondents currently participate in the Medicare Part D program.
3. Of the total number of prescriptions the pharmacists dispense monthly, some 34% of those are covered by Medicare Part D.

In addition, in certain urban areas, the percentage of prescriptions covered by Medicare and Medicaid reaches some 90%.

Continued closures will affect many patients who will not have the resources to travel distances of tens of miles to the nearest community to get their prescription needs met. In addition, these patients will have lost the important face-to-face interaction with their local pharmacist, who often will have great knowledge about their particular medical histories, including allergies and other sensitivities.

B. Cash Flow Problems are Very Real

That same survey found that:

1. 61% have obtained outside financing—from sources such as banks, wholesalers, credit unions and family members—to deal with the financial shortfalls they face regarding Medicare Part D.
2. The average current outstanding balance that is owed to a pharmacy by all Part D plans is just under \$70,000.

From a survey taken a month ago,

1. Some 93% of all respondents have found that pharmacy cash flow is worse as compared to before the implementation of Medicare Part D—only 1% found it to have improved.
2. Of those that have worse cash flow, some 36% are concerned about closing their pharmacy, 29% have asked their wholesaler for assistance, and 29% have opened a line of credit.

III. Suggestions for Change:

The Jones-Berry FAST bill addresses the cash flow problem, includes an adequate dispensing fee and also eliminates the harmful practice of co-branding.

1) *There needs to be a prompt pay provision.*

Implementation of Medicare Part D has caused a major cash flow problem for the community pharmacies on the front line of the program. Part D plans are paid each month *in advance* by Medicare, yet most Part D plans are using delaying tactics to enjoy a considerable interest-earning “float” on taxpayer dollars intended to reimburse pharmacies for serving their patients.

There are several bipartisan bills in Congress that address prompt pay. Community pharmacists and NCPA most strongly support H.R. 5182 and S. 2563—the Jones-Berry “Fair and Speedy Treatment (FAST) of Medicare Prescription Drug Claims Act of 2006” and the Cochran/Enzi/Talent/DeWine Pharmacist Access and Recognition in Medicare Act (PhARMA) of 2006.” In both bills, clean claims submitted electronically would be paid by prescription drug plans (PDPs), within 14 days, by electronic direct deposit. Other clean claims would be paid within 30 days. Pharmacists would also be notified within 10 days if there are problems with submitted claims.

These are the minimum changes that Congress should make. In real life operations, the Plans in fact have the ability to make these transactions much earlier than the 14 and 30 day deadlines—and that even with passage of legislation, the Plans will continue to unfairly profit from a longer than necessary “float.”

2) *Pharmacists need to receive an adequate dispensing fee*

Prompt payment will increase timely cash flow, but unless an adequate dispensing fee is set, independent pharmacists will continue to operate at the mercy of PDP “take-it-or-leave-it” contracts. These plans and the middlemen that manage them—the prescription benefit managers (PBMs) will continue to reap high profits.

If dispensing fees for generic drugs are not set at an adequate minimum level, then pharmacists will see an increase in the number of Medicare Part D drugs for which they do not receive enough compensation to cover costs.

An adequate dispensing fee will also insure that taxpayers will benefit from an increase in generic drug use, which saves both taxpayers and the program an average of \$94 for every generic prescription dispensed.

A legislative fix, such as is contained in the Jones-Berry bill, would encourage the use of generics, saving money and lowering health care costs.

What comprises an adequate dispensing fee? True costs to dispense should include all reasonable costs associated with a pharmacist’s time in checking information about an individual’s coverage or performing quality assurance activities. The total compensation that a pharmacist receives for dispensing a Medicare drug should consist of an adequate ingredient, or acquisition cost, a technical formula that is designed to reflect real life market forces, and an adequate dispensing fee minimum, which reflects overhead costs—the costs of doing business. Unfortunately, PDP plans have taken advantage of individual pharmacists to force—on a take-it-or-leave-it basis—plans that offer an inadequate dispensing fee.

An adequate dispensing fee should include, at a minimum:

- (i) the measurement or mixing of a covered Part D drug;
- (ii) filling the container for such a drug;
- (iii) physically providing the completed prescription to an individual enrolled in such a plan;
- (iv) delivery;
- (v) special packaging;
- (vi) overhead related to maintaining the facility and equipment necessary to operate the pharmacy, including, but not limited to, rent, mortgage, salaries of pharmacists and other pharmacy workers; and
- (vii) geographic factors that impact operational costs.

3) *The prescription cards that the plans issue should not be allowed to have a company specific logo on it.*

For example, one plan puts the Wal-Mart logo on their card. That seems outrageous to me and will make some patients think they have to switch pharmacies. Pharmacists are strictly prohibited from steering patients but the logo of a chain pharmacy is allowed on a card? Again, we need in law a prohibition against this practice, not just a recommendation by CMS that the plan can’t put a pharmacy logo on a patient’s prescription card.

We know we have lost patients who had the logo of a large chain pharmacy on their cards and thought they could not get their prescriptions filled at our pharmacy.

Pull out your social security card. Is there an advertisement on that card? There should not be any advertising on the card that serves as proof of admission to Medicare Part D. This is a clear violation of the anti-steering provisions spelled out in the marketing guidelines issued by CMS.

H.R. 5182, the Jones-Berry FAST Act—include a provision that prohibits co-branding, and we urge Congress to include such a provision in any Medicare Part D legislation that it might pass.

We know CMS has issued a call letter in which it requests PDPs to not include co-branding cards in their contracts for 2007. We are glad that CMS recognizes that co-branding is illogical, misleading and harmful to patients. A legislative fix is needed, however, as the advisory language is not yet binding and could be changed before it goes into effect.

Secondary issues include:

4) *Patients, doctors, and pharmacies need a standardized method of dealing with the plan formulary issues.*

Right now, if a prescription is not covered, a lot of plans send the pharmacy a message that says “drug not covered”. That’s it. No explanation as to why it was not covered. So, the pharmacy has to call the plan and find out why the drug is not paid for and what needs to happen to help the patient get their medication. The pharmacist then has to coordinate the paperwork between the patient, the doctor, and the pharmacy in order to help the patient get their medicine. This can take hours or even days. After all that time, the patient hopefully has not given up on the process and decided not to take their medicine.

There needs to be standardized messaging between all of the plans when they communicate with pharmacies and a standardized prior authorization procedure that reduces the administrative burden on patients, doctors, and pharmacies.

5) *Enrollment period needs to be realistic*

Patients were told that they could enroll as late as the end of the month and be in the system by the next day. That doesn’t happen and is not a realistic expectation by anyone in the system. The result is that beneficiaries are frustrated and pharmacy staff has to chase down claims to try to help get the prescription paid. This unrealistic expectation creates a chain reaction that upsets the entire benefit. Dual eligible patients should have a deadline of at least 15 days and non-dual eligibles should have at least 30 days to be entered into the system.

6) *Standardized Contract Rate*

Pharmacies have dozens of plans offering take-it-or-leave-it contracts. Family owned pharmacies have no ability to engage in any form of legitimate negotiations. As a result we are forced to sign contracts that reimburse us below our cost. We believe CMS should use its authority to provide reimbursement guidelines to plans or there needs to be legislation to address the situation so that pharmacies are able to stay in business and continue to provide the services I have described here today for the American public.

In conclusion, I would add that my husband and I enjoy being pharmacists and we believe we are making a difference for the thousands of patients who come in to our pharmacy. However, I am very concerned that the slower and lower Medicare payments this year on top of the massive Medicaid cuts that Congress passed last month will force thousands of family pharmacies to go out of business and strand millions of patients without access to the medicine they need to help them stay healthy.

Thank you again for inviting me to share my experiences with the Medicare Part D program with you. We hope you will work with us to help improve the Medicare Part D program so we can continue serving our patients.

Chairman JOHNSON OF CONNECTICUT. Thank you all for your testimony. I appreciate it very much.

Ms. Grisnik, I would be happy to work with you on some of the problems that you raise. In my part of the country, most of, or at least in many instances, the problems that you point to have been

worked out. I am interested that you still are—for instance, we can look into the payment process before this hearing.

The news that we are getting is it is back down to 2 weeks, but 2 weeks is what these plans have always been using. It is what is in their contracts. It is unlikely it will come in lower. Now, if you get somebody who comes in on day 14, it may be 2 weeks plus a day.

Ms. GRISNIK. As I left, I checked. It was still about four. Maybe it will shorten up in our system. It was still around four.

Chairman JOHNSON OF CONNECTICUT. We will talk to the Administration about that, because that is unbearable.

As to the doughnut hole, in States that have programs like Connecticut or Pennsylvania, there are about six States that have subsidy programs that rise about the 150 percent of poverty income, and Connecticut goes to 235. All of those payments count toward the doughnut hole.

So, those people are not exposed. We are saving the State so much money that they can easily start a program that pushes that 150 percent of poverty income up. For a Federal program, pairing with the States, that is actually higher than many of the programs that we do with States. So, it was a good place to start, and the logic was we are going to be saving the States so much money not just on their Medicaid patients, but also on their own State employees, that they can plow some of that money back into a program that provides some help for those who need it.

Then, of course, the bill also allows families to help with that doughnut hole. There will be developing community organizations that will help.

It is important to have those who can afford it to pay their freight, because if they do, their kids don't have to. When you look at the salaries that are currently being paid, never did any of us think we would live in a world in which there are really obscene salaries being paid. You certainly, when those people retire, want them to pay, make their personal effort.

So, structuring a plan for the years ahead, you have to take into account the seniors that are sitting there that could be paying if they needed to. There are 3,500. I will be one of them. I think we do have to structure a plan so that those who can carry 3,500 after the ordinary amount, because the threshold covers two-thirds of seniors, almost two-thirds of the seniors.

With wise use of generics, it is unlikely that more than a third of seniors will be affected by that gap. Of that third, a fair percentage, I would say 50, 60, 70 percent, can actually afford that personal effort contribution.

Now, I understand perfectly that there are those that can't. That is why we made other contributions eligible, and that is why I hope the States will begin to define that for themselves and maybe make a phase-out rather than a cliff. That is one of the refinements that has to take place.

I notice that Mr. Hayes was very critical of the structure of the plan. Earlier the issue was raised about the plan now costing \$800-and-something billion. That is over a different time frame. I would remind you that using \$1.3 trillion is not accurate because it is not a net figure.

The original plan that competed with ours when ours was \$400 billion was \$1.3 trillion. So, if ours has gone from \$400 billion to \$8 billion, theirs would have been gone from \$1.3 trillion to \$2.6 trillion.

Having people make a personal difference is that difference between \$2.6 and \$800 plus billion. Now, that is important, because seniors who can afford to help need to help, otherwise their children have to pay higher taxes. Today, as we speak, 50 percent of all Federal spending goes to people over 65.

Now, we want people over 65 to be secure financially and secure medically, but we have to do it in a way that those who can afford it carry more responsibility, and we did in the Medicare Modernization Act raise premiums, Part D premiums, for those with higher incomes. This is following that pattern.

I think we need to look at the margin; where does the 150, in my State it is 235 or 225—they keep pushing up. Some States will need to go to 250. Some need to go to 200 percent of poverty. We have some opportunities in the bill to do that.

I am much more concerned with the mechanics of the plan and leaving independent pharmacists exposed, as you line out in your testimony. Mr. Wolfe, as you comment as well.

While that is not the jurisdiction of this Committee, in fact, we are interested in those programs, those problems, and we will follow along with you and work with you to resolve them.

My time has expired. Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

Before I inquire of the witnesses, I just wanted to tell you that on our side, we are having so much fun that we want to continue this, so that we are going to invoke our rights under rule 11 to call witnesses to discuss Part D and have an additional hearing on this matter, and our letters outlined some of the witnesses that we would like to call.

Having taken care of that little bit of business, I would like to ask Mr. Schiesser, you note in your testimony that a CBO study says that Part D plans should save 20 to 25 percent off retail, but your discounts are only 15 percent below typical cash prices, which I presume is retail. Why the discrepancy?

Mr. SCHIESSER. I would have to look at the specifics of the CBO study, but my assumption is that incorporates estimates for savings related to formulary management and medical management. I would say that what we seek is to maybe create a very clear apples-to-apples program for you.

Oftentimes when we go in with State Medicaid programs, our company does a lot of Medicaid programs, and we are about to be doing that in Mr. Lewis's home State of Georgia and others. We typically see that we are able to save about 10 to 20 percent versus what the State Medicaid program is providing for the costs of the pharmacy.

Mr. STARK. Even in States that had the lowest price?

Mr. SCHIESSER. Yes.

Mr. STARK. In California, where we had Medicaid, we had a lowest price requirement for Medicaid drugs, and we found that the prices paid have been higher.

Mr. SCHIESSER. What we are finding, sir, while I am not familiar with the numbers in California in particular, what I think we have seen nationwide is with many of the States stepping in and keeping their Medicaid flags on for the first few months of this program, and as CMS has put in place the demonstration project to reconcile those payments back to the States, one of the issues has been that typically the States have been paying more than the plans, and so CMS is having to step in to keep the States whole.

Mr. STARK. I am looking for the numbers, but I want to say at the beginning of this, you are to be commended. I gathered that your loss ratio historically is right around 80, 81 percent for your medical plans; is that about in the ballpark?

Mr. SCHIESSER. For our Medicaid plan, that is correct.

Mr. STARK. That is good, I might add.

If you pull 5 percent, 6 percent, whatever you pull out of that for profit, you are still running around a 15 percent overhead. From my limited experience, where we used to be able to talk about loss ratios, that is about as good as it gets in the private sector.

How do you respond then to Mr. Emanuel's previous suggestion that if we had Medicare offer a plan, a direct plan in competition, they wouldn't be in competition with your managed care plans, but you don't have fee-for-service plans, so that is ostensibly what we would offer. We would probably offer a three, four—you can argue what the overhead of Medicare is, and presumably they would be able to buy at least as inexpensively as you can.

Could you compete with us?

Mr. SCHIESSER. So, I think we compete with Medicare fee-for-service today on the Medicare Advantage side.

Mr. STARK. That isn't doing worth poop. The Republicans will give that turkey up in no time. It doesn't have, what, 5, 10 percent of the Medicare beneficiaries signed up?

Mr. SCHIESSER. In many of the markets in which we compete, Medicare health plans have more than 20 percent penetration in the market.

Mr. STARK. Wow.

Mr. SCHIESSER. In fact, in a market—

Mr. STARK. If you were a betting man, we could bet about how long those turkeys would continue to fly.

Mr. SCHIESSER. We are very bullish on Medicare, very candidly, even when other plans around the country were, say, less bullish on Medicare.

Mr. STARK. You mean Medicare Advantage?

Mr. SCHIESSER. Yes, sir, thank you. We have always been committed to the program and trying to grow.

Mr. STARK. Well at 115 percent of what fee-for-service gets paid, it would take a genius to get into that and lose money. You are getting a 15 percent bonus over what fee-for-service is getting for arguably perhaps providing more limited benefits. So, that would be pretty tough to be in that racket and not make money.

Mr. SCHIESSER. I think ours—and, please, I defer to your tremendous knowledge in this area, but some of the counties I have looked at, especially when you consider the graduate medical education component of the Medicare reimbursement—for example, Broward County was one of the ones I mentioned in my testimony.

We are actually paid about a third of a point less than Medicare fee-for-service costs when you consider graduate medical education. I believe if you don't include it, it is about 99.5, so it is darn close.

Mr. STARK. I would like to look at those figures, because that will be an unusual district that that would happen.

My time has expired.

Chairman JOHNSON OF CONNECTICUT. I would just point out that the legislation itself does allow the plans to circumvent the law that allows States to have Medicaid get the lowest price. So, by circumventing those State laws that guarantee the lowest price to Medicaid, we are seeing, as you testified, Mr. Schiesser, that you can get prices below the Medicaid price. We wouldn't have been able to get prices below the Medicaid price if we hadn't circumvented those State laws. We are getting unusually low prices for that reason.

It is, Mr. Stark, true that the figure you are putting on the record of 115 percent, that was driven by the Rural Caucus in the Congress that pushed the Medicare reimbursement rate for rural areas up. So, when you average that out, it sounds higher. He gets lower than that because he is not—those plans that are not in rural areas. So, the national average figures make it look like there is one price being offered, but the reality is that those are in the rural areas where there were no plans, and the goal was to pull plans into the rural areas; not a policy I agreed with, but that has pushed the average up.

Mr. English.

Mr. ENGLISH. Thank you, Madam Chair.

It is a real privilege to have you come and gone from Mercer County in my district and take your time to present your own perspective as someone who is out on the front lines, so I very much appreciate it.

I have been hearing from a lot of local pharmacists that they have faced some special challenges in the implementation of this plan.

A couple of things in your testimony I was very taken with. In your county, as you know, as of April 18, nearly 15,000 out of the slightly over 21,000 individuals over 65 have prescription coverage. There has been a significant number of people participating in this program.

I was struck by one of your recommendations on prompt pay. On the face of it, it is a sensible suggestion. You suggested there needs to be a prompt pay legislation that would direct prescription drug plans to pay clean, electronically submitted claims within 14 days, and other clean claims within 30 days.

I am curious. How does this compare with the payment you received from other non-Medicare private payers?

Ms. GRISNIK. That is very similar.

Mr. ENGLISH. Does the NCPA have a Part D plan, do you know?

Ms. GRISNIK. Not that I know of. There is community—

Mr. ENGLISH. Community Care?

Ms. GRISNIK. Community Care. I am not certain what the affiliation is.

Mr. EVERETT. What is that plan's payment policy?

Ms. GRISNIK. Their payment policy. Now, I would have to double-check to make sure with my secretary, because I do not check all of these, but I would say it is 14 to 21 days right now.

Mr. EVERETT. So, it is actually—you are not even sure that it would fall within the 15-day parameter.

Ms. GRISNIK. Right, 14.1. I believe, don't quote me. I could double-check and let you know, Mr. England.

Mr. ENGLISH. I would be curious. Our impression is that they pay more within a 30-day time frame.

Ms. GRISNIK. I could check my records at the store and just let you know.

Mr. ENGLISH. Is 30 days, in fact, an unreasonable time frame in which to pay claims? After all, my experience with my credit cards is such that a 30-day turnaround time is not unreasonable.

Ms. GRISNIK. Unfortunately we must—our wholesalers electric fund transfer weekly, so it does put a strain on an independent pharmacy because we are paying our bills every week.

Mr. ENGLISH. Sure.

Ms. GRISNIK. It does put—as you are putting out, the faster you can get it in, the easier it is to make those payments to your wholesalers.

Mr. ENGLISH. You also state in your testimony that an adequate dispensing fee should be set at an adequate minimum level. In your view, who should set that fee? Should one fee apply to all plans equally, or would there be geographic or other variations? How would you envision or your association would envision that fee be updated?

Ms. GRISNIK. That I would like to double-check and get back to you. I do feel it needs to be an adequate fee that would cover a pharmacist, at least their overhead.

As I said, with a \$2 prescription, there is no way that it even covered the bottle and the label for me just—let alone I happened to be working and it is my business. If I hire a pharmacist, I am paying large sums per hour and my technicians. There needs to be some equitable fee so that we are getting paid for our—at least for our overhead.

I would like to double-check. I could get back to you with that information.

Mr. ENGLISH. I would welcome it.

[The information follows: PENDING.]

Mr. ENGLISH. Again, I appreciate your independent take on these things. I guess my question is if the government starts setting dispensing fees based on the variables you referenced in your testimony, they will be subject to fluctuations, which at various points may help or hurt the pharmacies that we are trying to help here. As a result, I am a little skeptical on how the fee structure would work.

The other point I wanted to make, from your testimony, you bring up cobranding by drug plans, the use of company logos like Wal-Mart on beneficiary plan cards. What you found is that this has the potential to steer beneficiaries away from independent pharmacies.

Ms. GRISNIK. It does do that indeed. I had a patient this past weekend who brought me his insulin that he could not buy from

the other pharmacy. He said, I guess I will have to pay full price here because you do not take my card.

Mr. ENGLISH. You also acknowledge, though, that CMS is attempting to address the issue. Dr. McClellan in his testimony states that with the beginning of fiscal year 2007 marketing on October 1 of this year, PDP sponsors will not be able to place co-branding names and logos on their ID cards.

This seems to me to be one of those areas where CMS has been responsive to a lot of complaints they have heard.

Ms. GRISNIK. Are they requiring them?

Mr. ENGLISH. Do you have any problem with what they are doing?

Ms. GRISNIK. No. Are they requiring them?

Mr. ENGLISH. Absolutely.

Ms. GRISNIK. Who is going to enforce it?

Mr. ENGLISH. CMS is. It will be part of the contracting process. Chairman JOHNSON OF CONNECTICUT. Will the gentleman yield?

Mr. ENGLISH. Certainly.

Chairman JOHNSON OF CONNECTICUT. It is part of next year's standards. You can't do anything about it this year. It is next year's because the cards have already been issued. The next year's competition.

Ms. GRISNIK. That leaves a lot of time frame though.

Chairman JOHNSON OF CONNECTICUT. I appreciate that, but the cards are already out. How are you going to do that? We can do a better job of educating them. We will talk to them about it.

Mr. ENGLISH. Thank you, Madam Chairman. I appreciate your coming from Mercer County to share.

Ms. GRISNIK. Thank you for having me.

Chairman JOHNSON OF CONNECTICUT. Mr. Lewis. I am glad to see, Mr. Lewis, that 69 percent of your seniors have signed up. That is more than are signed up for the Medicaid—who are eligible for the Medicaid program. So, that is really great.

Mr. LEWIS. Thank you very much, Madam Chair. Thank you very much. Let me thank all of the witnesses for being here.

Mr. Wolfe, Rite Aid must have customers that have already reached the doughnut hole. Do you think you would have a customer that won't be able to afford that prescription under the coverage gap?

Mr. WOLFE. I am concerned about that, Congressman. That is where I think Madam Chairman talked about some assistance programs that are available in States in Pennsylvania. The Program of All Inclusive Care for the Elderly is looking to address that issue for lower-income Pennsylvanians. I think in other parts of the country, some private sector assistance programs along the lines of the manufacturer assistance programs could also go a long ways. I was glad to hear that Office of Inspector General (OIG) has set out a framework for a formula that would allow them to step in and offer some assistance in that regard.

Mr. LEWIS. Wouldn't it hurt your business if your customers are not able to pay for their prescription drugs?

Mr. WOLFE. More than their business, it would potentially harm the patient. Our primary concern is that the patient get the medications they need; but certainly, yes, it would not be good for our business either.

Mr. LEWIS. Do you plan to help any of your patients pay for their prescription drugs during the time——

Mr. WOLFE. Congressman, we do help with that. The pharmacies are held to their discounted rate that they have contracted with the payer and passed that to the beneficiary while they are in the doughnut hole.

They do not revert back to a cash price.

Mr. LEWIS. Ms. Grisnik, thank you for being here. Thank you for your testimony. We have heard many stories to back up your testimony that payments to pharmacists by Part D, plan sponsor, are too low, too slow. You have mentioned that some pharmacists have gone out of business.

Ms. GRISNIK. That is my understanding, yes.

Mr. LEWIS. Really. Could you describe, what do you mean by too slow and too low; they are not paying enough?

Ms. GRISNIK. Well, the too slow, of course, is the time frame from the time the drug was dispensed and then you get the payment for the actual prescription. Too low would be as an example, especially with our generics, that that prescription, that particular prescription I spoke of that is \$2, was a generic prescription. I can't dispense a prescription for \$2. I can't give somebody a prescription for \$2.

Mr. LEWIS. You are independent. You are not part of a big chain?

Ms. GRISNIK. I am not. We own our own pharmacy. We do have buying groups that help us facilitate buying so that we do get the best price possible. So, we buy with several others. We buy with large wholesalers, we buy with co-ops to get the price of our goods down as far as we can. I can't dispense a medication for \$2. That is it.

Mr. LEWIS. Do you have any idea how many other independent pharmacies, drugstores, will be forced to close if the pay is inadequate and too slow?

Ms. GRISNIK. If the pay is inadequate, especially on generic, it will not be just independents, it will hit the chains, too. It will be devastating to the pharmaceutical community.

Mr. LEWIS. Do you have any recommendation for this Committee, for CMS?

Ms. GRISNIK. Well, they need to look at their payment structure, especially for generic.

Mr. LEWIS. Mr. Hayes, do you have anything to add?

Mr. HAYS. I will follow up on your question about what pharmacists can do when patients show up during the doughnut hole. I do commend many pharmacists, community pharmacists, chain pharmacists, who did right in January and February to save the day, saved the lives in many cases for many people who had lost their Medicaid drug coverage and were being switched theoretically into the Medicare drug coverage. Many really did help and simply gave free prescriptions. Ultimately 35 or more States had to come in with emergency plans to help these folks.

I think that what we heard today, though, is that is not something that the pharmacists continue do to do to bail people out to save folks' lives. I think that is why probably most of us are here today to look for help from Congress.

Mr. LEWIS. Thank you.

Madam Chairman, my time has expired.

Chairman JOHNSON OF CONNECTICUT. Let me just comment—never mind. Let me recognize my friend from Texas.

Mr. DOGETT. Thank you so much, Madam Chair. Thanks to all of you for your testimony and for staying here late with us through the votes.

Mr. Hayes, we have seen, of course, this afternoon a tremendous amount of collective back-patting and congratulatory comments about what a wonderful job has been done on this Medicare Part D program.

I am interested in particularly the folks that I understand is one of the focuses of your organization; that is, folks who have qualified for the so-called Extra Help program. We are now down to 2 weeks, less than 2 weeks before the statutory or official deadline of May 15. I know it has been extended for those folks. What portion of those who are eligible to receive that help, the people that are in greatest need among our seniors for the prescription drug program, what portion of them are signed up in the great success we heard about today?

Mr. HAYS. According to most government estimates, there are about 8 million people poor enough to be eligible for this Extra Help program. These are folks who simply cannot afford to pay their way through the doughnut hole, who cannot afford the copayments and the premiums.

Ms. Disman from the SSA this morning, or this afternoon, I think, reported that about 1.7 million of those 8 million folks had, in fact, been enrolled. I think that is 17 or 18 percent have enrolled up to now.

Mr. DOGETT. After all the great efforts and all the great success that we have heard about today, and the people, the greatest need, the success rate is about 17 or 18 percent?

Mr. HAYS. That is correct. Even comparing it, it was even depressing to me to have the witnesses earlier today. To compare whatever, the Part D enrollment rate or, much worse, this low-income subsidy, also known as Extra Help program, enrollment rate to food stamps, Medicaid and other disgraceful rates that we have for other programs is somewhat infuriating, I think, given the amount of human need to have a program that goes unmet, to have—

Mr. DOGETT. It really is. The 17 or 18 percent is an F or an F minus, if there is such a grade, in my book, and that is the grade that applies, I think, in some other areas.

Mr. DOGETT. To me, it has been a big question of whether the taxpayer has been fleeced in this bill more than the seniors, but I think there is enough of a problem to go around. Much of that problem was also discussed by you, Ms. Grisnik, and it is consistent with the concerns that I have heard from many of the small towns that I represent particularly; and a little different population perhaps than you have, but similar concerns, where I have many

people who speak most comfortably in Spanish and going to a community pharmacy down the block who can speak with them in Spanish about the counseling that they need and the interaction between the drugs is a big factor. as I talk to some of those pharmacists, some of them tell me they get no dispensing fee at all for doing that for an extended period. That has been the experience of you and some of your colleagues.

Ms. GRISNIK. I'm sorry? No dispensing fee?

Mr. DOGGETT. That they receive no dispensing fee on the drug that they might provide counseling to someone about it at all. They get zero.

Ms. GRISNIK. That is correct. On that one prescription I got no dispensing fee.

Mr. DOGGETT. Have you and your organization turned to the CMS people to ask that CMS intervene and try to assist on this dispensing fee issue?

Ms. GRISNIK. I have not personally. Whether my organization has, that needs to be addressed, I am sure.

Mr. DOGGETT. Another concern that I have had voiced from some of these pharmacists is they do not get any electronic payments. I am sure that the plans themselves expect to get electronic payments from the government, but this is not happening to the community pharmacists.

Ms. GRISNIK. That is correct. Some are not doing electronic. We get electronic payments from so many of our third parties. It should be all.

Mr. DOGGETT. Basically the relationship between the individual pharmacists and some of these plans, the prescription benefit management organizations, is not dissimilar from that between an individual physician and a health maintenance organization; that all the bargaining power is on one side, and you are charged for making an inquiry if someone comes into your pharmacy and thinks they have coverage under a particular plan and you contact them, that you get a charge just for making an inquiry.

Ms. GRISNIK. That is correct. If you transmit on line to do an inquiry, you do get charged. That is correct.

Mr. DOGGETT. So, you may get charged for making an inquiry for someone who did not keep up their premium or was dropped off a plan.

Ms. GRISNIK. Yes.

Mr. DOGGETT. That may be on the same prescription that you get no dispensing fee on.

Ms. GRISNIK. That is also correct.

Mr. DOGGETT. Thank you so much for your testimony.

Chairman JOHNSON OF CONNECTICUT. Thank you. Ms. Grisnik, how frequently does the State pay you?

Ms. GRISNIK. Our State pays us every week.

Chairman JOHNSON OF CONNECTICUT. Are not many of your patients Medicaid or dual-eligible and fall under that payment regimen?

Ms. GRISNIK. Our regular access patients pay us every week, but some have fallen—they have routed them out to different HMOs and those, unfortunately, are not keeping up the same way.

Chairman JOHNSON OF CONNECTICUT. In those instances where the State has stepped in and just paid while they straighten some of those enrollment issues out, have they paid promptly?

Ms. GRISNIK. In the beginning, from those particular ones?

Chairman JOHNSON OF CONNECTICUT. That was about 2 or 3 months.

Ms. GRISNIK. I would have to double-check and get back to you. Actually my office manager would know that better than I.

Chairman JOHNSON OF CONNECTICUT. Mr. Hayes, what percentage of that group are on Medicaid, this 17 or 18 percent?

Mr. HAYS. None, Madam Chairman. The people who are on Medicaid were automatically enrolled into the extra health program so the 8 million folks that have been targeted by a lot of our groups to go out and enroll people manually, if you will, those are people who are still very poor but not Medicaid eligible. Am I confusing that?

Chairman JOHNSON OF CONNECTICUT. You are confusing numbers in the sense that when the witness from SSA testified, she was testifying to a very narrow group. I do not know the relationship between her number and the other numbers, but the 150 percent of poverty and under presumably are in this group that the States and the Federal Government are transferring information about and hoping to work out and will not be affected by the May 15 deadline.

Mr. HAYS. That is correct. The 8 million people who are eligible for signing up for extra help can do it May 16.

Chairman JOHNSON OF CONNECTICUT. So, it is not right to say that those who need it most are not getting it. Those who need it most not only are getting it, but, because there have been problems in the system, they have no deadline.

Mr. HAYS. No. The people who are getting extra help, the 6 million people with Medicaid, are indeed getting that extra help, Madam Chairman, but they lost their—many States—better Medicaid coverage in the process. So, it is the people who really we are reaching out to—

Chairman JOHNSON OF CONNECTICUT. I appreciate that the ones that need it most are the ones like—States like Connecticut and Pennsylvania subsidize, and other States. The State has not been subsidizing them and they were paying themselves because they mostly did not have prescription drug coverage.

Now a lot of what we are seeing in the 8 million that did sign up themselves were mostly people who did have prescription drug coverage before. They are the ones we wanted to reach. We think that by the time sign-up is done, there will be 4 million not covered; 4 million not participating or not needing to participate; and of those, 2 million are expected to be in this group that is hard to reach, that is low income. The other 2 million, it will not be clear exactly who they are until we get further down the line.

To even be talking about 4 million or 5 million from 42 million in 125 days is an accomplishment. That is all; I think it is important for the record to reflect. It is important for the record to reflect that we still have a job to do, and it is also important for the record to reflect that we have had a better partnership than we ever had, and that some of the problems with the small pharmacies are due

to the contracts. As the Administration looks at what are going to be the requirements in the contracts in the future, which is what they are doing now, that is our chance to address contracting problems.

The government has never set, to my knowledge, pharmacy reimbursement rates. That is usually a matter of contract, and a pharmacy can choose to participate or not choose to participate.

It is very helpful to have your testimony about what you see as the problems out there in the front line. We will reread those just as carefully as anything else. It is a great point of pride that so many of you have been out there, hands on, one to one; because, in a new program, especially when it involves insurance, should be one to one. Nobody likes choosing an insurance plan, even if it is one their employer offers.

I would have to say that on the Medicare Advantage plans, I had a senior in Waterbury, Connecticut give me a long lecture on why was I not talking about them more, because he was paying zero premium for drugs and some additional benefits, including copayments.

So, these plans are offering a very good bundle of benefits. The reason they can do it is because they can use drugs in preventative health to keep people out of hospitals and emergency rooms, and that cuts their costs.

So, we can learn something from them, particularly as we move into an era in which we need to help seniors manage an array of chronic illnesses. We do not need to be like them. We just need to learn how to provide more integrated care, and the systems do that.

We have a lot of options out there. We have had some remarkable accomplishments. We have some problems. The only way to confront them is get them on the public record, which we have done today. We will help to work out the remaining problems with you. Thank you very much for being here. We appreciate your attendance.

The hearing will recess for just a few minutes.

[Recess.]

Chairman JOHNSON OF CONNECTICUT. Before I adjourn the hearing, I would like to respond to the letter handed to me by my Ranking Member, Mr. Stark, and signed by the members of the minority. It is a letter notifying that they want to have a rule 11 hearing. It claims that we failed to include important witnesses necessary to enable the Subcommittee to fully examine the issues and they, at a minimum, would likely invite.

Now they would like to invite a State Medicaid director. They had requested that such a director testify at this hearing, and we did not have room for that. So, that is one that we did not invite.

They wanted to invite UnitedHealthcare. We did invite UnitedHealthcare. We also invited AARP. Both of them rejected the invitation.

Mr. DOGGETT. Will the gentlewoman yield? Just on the UnitedHealthcare, my understanding was that they agreed to come and they were not invited.

Chairman JOHNSON OF CONNECTICUT. They were invited and they declined to come.

We invited AARP, who works with them, and they declined to come.

GAO and the Kaiser Family Foundation were discussed, and then we have an e-mail dropping the request for them.

You cite the OIG that you would like to invite, but you never suggested the OIG for this hearing. In the letter you suggest that you would like to invite retiree coverage, raise the issue of retiree coverage, but you did not raise that issue before this hearing. In the letter you asked to raise the issue of beneficiary membership organization, have a beneficiary membership organization testify. You did just have that at this hearing, and he did a very fine job.

So, I wanted to put on the record that of those that you say you were likely to invite, some we agreed to invite and they declined; some you dropped, some you invited, and others were not brought up. Nonetheless, you have a right to have a hearing. We have a right to set the time. So, we are going to have this hearing tomorrow at 2 o'clock.

Thank you. The hearing is adjourned.

[Whereupon, at 6:39 p.m., the hearing was adjourned.]

CONTINUATION OF THE HEARING ON IMPLEMENTATION OF THE MEDICARE DRUG BENEFIT

WEDNESDAY, MAY 4, 2006

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:50 p.m., in room 1100, Longworth House Office Building, the Honorable Nancy Johnson (Chairman of the Subcommittee) presiding.

Chairman JOHNSON OF CONNECTICUT. Good afternoon, everyone, and welcome to this continuation of the Committee's hearing on the implementation of the Medical Part D prescription drug benefit. I am delighted to have another opportunity to talk about this program that is so important in the lives of our seniors and to talk about the remarkable partnerships that our Centers for Medicare and Medicaid Services (CMS) has developed with the private sector, unprecedented in the effort by any Administration and any part of the Government to get the public involved in a benefit that the Congress has funded.

Whether it is Food Stamps, whether it is Medicaid, whether it is Supplemental Security Income benefits, we have never seen such a high level of participation in 125 days as we have been able to generate in the Medicare prescription drug benefit, and that is because it is so important to the seniors of America.

From April 20 to April 27, 36,906 seniors were signing up per day. From April 27 to today, 56,303 seniors per day are enrolling. That is because, as I have seen in my own district, seniors are saving hundreds of dollars, thousands of dollars; in one instance, a couple saving \$5,000. If you lived on a fixed income, and that income was low or moderate, you, too, would want help with your prescription drugs, and I am very, very pleased that the Medicare Part D plan is serving seniors all across America, and we are on track by May 15 and the weeks thereafter, as low-income seniors have a right to continue signing up, we are on track for Medicare Part D and other plans that working Americans over 65 are participating in to have 90 percent of the 42 million seniors in America with good drug coverage.

Over the next few months, I believe at least 2 of those last 4 million will sign up. Even without them, a 90 percent coverage rate in 125 days of our 42 million seniors is an absolutely astounding record. So, I am delighted to be here today to talk again about this

program. Of course, implementation challenges, we heard yesterday how those challenges were owned by the Government; never.

I have served under four Presidents. I have served under many CMS administrators. Never have I seen the Government so willing to take ownership of problems, create collaborative relationships to solve them, and put in place the ability to deal with the problems, to get to the people who need the benefit. We heard about all the partners, over 10,000 partners yesterday; indeed, a remarkable performance, and one through which in the future, make no mistake about it, those partnerships are not going to service just in terms of getting people involved in the Medicare Part D benefit, which is important, but far more important than any one benefit, those partnerships are going to help us close the gap between minority and other senior groups in health care by giving us the means to reach out to our seniors and deliver to them the preventive benefits we passed the preventive benefits we have prepared in the Medicare Modernization Act which go directly to the issue of helping the seniors of America manage the chronic illnesses that plague their elder years.

So, those partnerships are just the beginning of a relationship that is important for government to be able to help its constituents lead healthier lives. So, I am happy to be here, and I yield to my colleague, Pete Stark.

Mr. STARK. Thank you, Madam Chair, and thank you for your courtesies in extending this hearing to accommodate additional witnesses. I want to thank the witnesses who appeared today and appreciate their willingness to appear on such short notice.

Some proponents of Part D seem to believe that appearance may be as important as performance, but given the lives and dollars that are at stake, I am not sure that is an acceptable position. This Committee should be rigorous in its oversight, and we have heard time and time again about this being the biggest change to Medicare since its creation.

Yet, yesterday was our first hearing, and we have a lot to cover. With this law affecting tens of millions of people and spending up to a trillion dollars in the next 10 years, I think our obligation to account for that spending and know what is happening is paramount. While, as you know, I am no fan of this program or the partisan process by which it was created, my Democratic colleagues and I I think have been very clear that we do not want to see it repealed. We do feel that definitely, changes are needed.

The Administration and Committee leadership would like to chalk everything up to run of the mill implementation problems and suggest it is all being worked out. I do not believe that is the case, and neither do our constituents, objective policy experts, State Medicaid directors, many physicians and pharmacists. The problems seem to run far deeper, and while I must acknowledge there is not much we are likely to be able to do this year—we never seem to be able to do anything courageous in even-numbered years, but if we had to resort solely to parliamentary tactics, I think this would be unlikely.

Once the Committee has a full and common understanding of the situation, I hope we can use what we have learned to improve the program, and today's witnesses should give us a broader under-

standing of how the law is affecting the beneficiaries, including those most vulnerable, for whom this law was allegedly targeted. The witnesses, I think, will help us understand why it is difficult for the beneficiaries and their advisors to navigate this program and help clarify the record with respect to drug prices, and we are going to hear from United, the American Association of Retired Persons, the largest Part D plan, and they are already covering, I think, 4.5 million beneficiaries and have received \$4.5 billion or thereabouts from CMS. Seems to me that they were an outstanding witness to hear from. We are going to hear about the importance of oversight and making the data publicly available.

We have 56,000 enrollees a day. If that is the correct figure, we would need 130 more days to get the remaining 7.2 million enrolled, and I did that math with my shoes and socks on. Yet, we only have 11 more days, so that by token, we are hardly going to get 560,000, 600,000 in.

So, the next step, I believe, is to extend the deadline and also the corresponding late enrollment penalty. To do so at this hour would achieve the goal of having a deadline to hasten enrollment but not penalize those who have not been reached, were misinformed, could not navigate the system, procrastinated, and it would probably only bring, according to CMS' concern, more healthy people into the program, and that is exactly what we want to do. That will hold the cost down.

So, I look forward to today's testimony and discussion to see if we can get closer to getting those last 7 or 8 million people in the program. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Welcome, Mr. Waxman.

STATEMENT OF HON. HENRY WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Well, thank you very much, Madam Chairman and Members of this Committee. I am honored to have been invited to come to the Committee on Ways and Means and talk about the subject of this Medicare prescription drug benefit, but I do not need to tell anyone on this Committee of the problems with the new drug benefit. You have all been back to your districts and heard the complaints from seniors who cannot get the drugs they need, or cannot cut through the plans' complications—the dozens of different plans, each with different copays, premiums, deductibles, and formularies—to sign themselves up.

Now, as the May 15 deadline for enrollment looms, millions of seniors face life-long penalties for not signing up for this flawed program in time. The Medicare bill is increasingly looking like a poor deal for too many seniors. The new program is incredibly complicated. Too many of our most vulnerable seniors are falling through the cracks, and it is costing seniors and the taxpayers too much.

One of the justifications for the plan's confusing scheme involving dozens of private insurers is that these plans would be able to provide seniors with lower prices. This is simply not the case. The prices that the plans are charging seniors are way too high. They are well above prices that aggressive Government negotiators like

the Veterans Administration (VA) pay. They are well above the prices that consumers pay in Canada. They are even higher than the prices available through large retailers.

I would like to give you a few examples of the kinds of price differences that we are seeing. Recently, my staff looked at the prices offered by 10 leading Medicare insurance plans for 10 popular brand name drugs. The average Medicare prices were more than 75 percent higher than the prices negotiated for the Federal Government by the VA. They were almost 60 percent higher than prices in Canada. They were higher than the prices at Drugstore.com or Costco.

With the new Medicare plans, beneficiaries pay an average price of \$111 for the ulcer drug Protonix, but the Federal Government pays only \$24 for the same drug, a 425 percent difference. Similarly, Medicare beneficiaries pay an average price of \$129 for the heartburn medication Nexium, but consumers in Canada pay only \$67.

The prices offered by the Medicare drug plans did not just start out high. They also went up, and they did so rapidly. CMS began posting information on the prices offered by the Medicare drug plan in November 2005, and seniors began choosing plans and signing up in December. At this point, many were locked into a plan. In February, my staff looked at whether plans were increasing their posted drug prices for beneficiaries. They found that in the first two months of the Medicare program, the drug plans increased their prices by over 4 percent. The vast majority of plans increased their prices, with some plans increasing prices by over 10 percent.

These price increases in the first two months of the program were greater than the inflation rate for all of 2005. They were over twice as high as drug price increases in Canada, and contrary to critics of the analysis, they increased even faster than the published average wholesale price for the same drugs. These massive price differences and the rapid price increases make little sense. For beneficiaries, they increased out of pocket drug costs, reduced purchasing power, and undercut the assistance provided by the Medicare drug benefit. For taxpayers, who will also end up footing the bill for higher drug prices, they will ultimately mean billions of dollars in extra costs.

There are other problems with the Medicare drug benefit as well. One of the biggest complaints that we have heard from seniors is they are not able to get the drugs they need, and they are encountering hidden restrictions on drugs that are listed on the plan formulary. The problem is that plans are using additional tactics to restrict use. They require prior authorization before a drug can be prescribed or limit the quantity of a given drug that they will pay for or require that the beneficiaries use a different drug first.

The use of these restrictive tactics mean that even if seniors have carefully researched a Medicare drug plan, they can still encounter obstacles in obtaining medications. While the use of restrictive tactics by Medicare drug plans is widespread, the disclosure of their terms is virtually nonexistent. Over two-thirds of the Medicare drug plans contacted in a phone survey were unable to describe accurately how prior approval, step therapy, or volume limits worked with their particular plan. Several times, plans were called

twice consecutively and gave completely different answers to identical questions about whether plans restricted access to drugs and how these restrictions worked.

The net result of all of this is that even if they carefully researched the plan, too many beneficiaries cannot get the medicine they need. The complexity of Medicare Part D is putting many seniors in a Catch 22 predicament. They are not able to make a fully informed choice about a Medicare drug plan without knowing whether the plan will limit their access to drugs listed on the plan formulary, but even though the use of these restrictive tactics is common, it is nearly impossible for seniors to learn their terms until they have already subscribed and then been denied access to the drug.

Well, over and over, we talk to seniors; we investigate the facts; we come across a common theme: the Medicare prescription drug plan is not working for seniors. It is too complex. Many seniors are unable to sign up; are unable to get the drugs they need when they do sign up for a plan, and the plans are just not able to control prices and give seniors the low cost that they were promised.

We need to take another look at this Medicare plan. Clearly, given the complexity and confusion surrounding the program, we should extend the May 15 deadline. Seniors should not be penalized because Congress passed the legislation that created this flawed drug benefit, and we should do all that we can, including letting the Government negotiate for better prices to guarantee that seniors and taxpayers get their money's worth.

Thank you for this opportunity to make this statement, and I would be happy to answer any questions that Members may have.

[The prepared statement of Mr. Waxman follows:]

Prepared Statement of The Honorable Henry Waxman, a Representative in Congress from the State of California

Thank you for asking me to testify today.

I don't need to tell anyone on this Committee about the problems with the new drug benefit. You've all been back to your districts, and heard the complaints from seniors who can't get the drugs they need, or can't even cut through the plan's complications—the dozens of different plans, each with different copays, premiums, deductibles, and formularies—to even sign themselves up. Now, as the May 15 deadline for enrollment looms, millions of seniors face life-long penalties for not signing up for this flawed program in time.

The Medicare bill is increasingly looking like a poor deal for too many seniors: the new program is incredibly complicated; too many of our most vulnerable seniors are falling through the cracks; and it is costing seniors and the taxpayers far too much.

One of the justifications for the plan's confusing scheme involving dozens of private insurers is that these plans would be able to provide seniors with lower prices. But this is simply not the case. The prices that the plans are charging seniors are way too high. They are well above prices that aggressive government negotiators like the VA pay; they are well above prices that consumers pay in Canada; and they are even higher than the prices available through large retailers.

I'd like to give you a few examples of the kinds of price differences that we are seeing. Recently, my staff looked at the prices offered by ten leading Medicare insurance plans for ten popular brand name drugs. The average Medicare prices were more than 75% higher than prices negotiated for the Federal Government by VA; they were almost 60% higher than prices in Canada. And they were higher than the prices at Drugstore.com or Costco.

With the new Medicare plans, beneficiaries pay an average price of \$111 for the ulcer drug Protonix. But the Federal Government pays only \$24 for the same drug—a 425% difference. Similarly, Medicare beneficiaries pay an average price of \$129 for the heartburn medication Nexium. But consumers in Canada pay only \$67.

The prices offered by the Medicare drug plans didn't just start out high. They also went up—and they did so rapidly. CMS began posting information on the prices offered by the Medicare drug plans in November 2005, and seniors began choosing plans and signing up in December. At this point, many were locked into a plan.

But in February, my staff looked at whether plans were increasing their posted drug prices for beneficiaries. They found that in the first two months of the Medicare program, the drug plans increased their prices by over 4%. The vast majority of plans increased their prices, with some plans increasing prices by over 10%.

These price increases in the first two months of the program were greater than the inflation rate for all of 2005. They were over twice as high as drug price increases in Canada. And, contrary to critics of the analysis, they increased even faster than the published average wholesale price for the same drugs.

These massive price differences, and the rapid price increases, make little sense. For beneficiaries, they increase out-of-pocket drug costs, reduce purchasing power, and undercut the assistance provided by the Medicare drug benefit. For taxpayers, who will also end up footing the bill for higher drug prices, they will ultimately mean billions of dollars in extra costs.

There are other problems with the Medicare drug benefit as well. One of the biggest complaints that we've heard from seniors is that they are not able to get the drugs they need, and that they are encountering hidden restrictions on drugs that are listed on a plan formulary.

The problem is that plans are using additional tactics to restrict use—they require prior authorization before a drug can be prescribed, or limit the quantity of a given drug that they will pay for, or require that beneficiaries use a different drug first. The use of these restrictive tactics means that even if seniors have carefully researched a Medicare drug plan, they can still encounter obstacles in obtaining medications. And while the use of restrictive tactics by Medicare drug plans is widespread, the disclosure of their terms is virtually nonexistent.

Over two-thirds of the Medicare drug plans contacted in a phone survey by my staff were unable to describe accurately how the prior approval, step therapy, or volume limits worked with their particular plan. In a number of cases, plan representatives had no idea what these terms even meant. In a number of other cases, Medicare drug plans provided erroneous or conflicting information about restrictions. Several times, plans were called twice consecutively and gave completely different answers to identical questions about whether plans restricted access to drugs and how these restrictions worked.

The net result of all this is that even if they carefully research a plan, too many Medicare beneficiaries can't get the medicine they need. Beneficiaries with high blood pressure are not able to obtain their medication in their prescribed dose. Arthritis patients have been denied the recommended doses of painkillers that they need. Mental health patients are unable to get appropriate doses of antipsychotic medications. These stories are heartbreaking, and they show how far short this program falls from what it should have been—a simple and dependable part of Medicare.

The complexity of Medicare Part D is putting many seniors in a "Catch 22" predicament. Seniors are not able to make a fully informed choice about a Medicare drug plan without knowing whether the plan will limit their access to drugs listed on the plan formulary. But even though the use of these restrictive tactics is common, it is nearly impossible for seniors to learn their terms until after they have subscribed and been denied drug access.

Again and again, when we talk to seniors and investigate the facts, we come across a common theme. The Medicare prescription drug plan is not working for seniors. It's too complex, leaving many seniors unable to sign up or unable to get the drugs they need when they do sign up for a plan. And the plans just are not able to control prices and give seniors the low costs that they were promised.

We need to take another look at this Medicare plan. Clearly, given the complexity and confusion surrounding the program, we should extend the May 15 deadline. Seniors should not be penalized because Congress passed the legislation that created this flawed drug benefit. And we should do all that we can—including letting the government negotiate for better prices—to guarantee that seniors and taxpayers get their money's worth.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Representative Waxman.

You know, in Fort Smith, Arkansas, the St. Boniface School sixth graders took on as their community service project learning to use the Pathfinder, and under instruction, with careful instruction, they learned to use it. One day a week, they dedicated to signing up seniors in their hometown, and they signed up 300 seniors. Ethan said to the First Lady when she visited down there recently to commend them, he said, this is a mountain out of a molehill. This is not hard.

I tell that story because I have had many a senior call to my office and say, oh, this is so complicated. We say, have you tried it? They say, oh, no, no. In the papers, they say it is so complicated. I said, well, try it. Let us help you try it. Indeed, when they get their prescriptions written down and their number written down, they find it not so hard, and the proof is in the pudding. In the Kaiser Family Foundation survey, they found that 54 percent of the seniors who were signed up chose their own plans.

When you put that up against the overwhelming satisfaction rate and the majority that either understood very well or well their plans, you have to say that when you use the tools that are provided, and you follow the directions, seniors are finding this a wall they can penetrate, and they are signing up in droves.

You also have to consider, at least I am surprised that you do not take a little more time to think through the extraordinary partnerships that the Government has developed with the Hispanic community, the National Association for the Advancement of Colored People, black churches; well, out at Martin Luther King's own church, they are having yet another signup. At black churches throughout America, there have been signups. There are Hispanic hotlines, Spanish-speaking hotlines in many States in many areas; Meals on Wheels, it really is about time Government understood they need to speak to people where they are, and if they cannot speak to them through the written word or the computer word or the telephone voice, they need to speak to them one-on-one, person-to-person.

That is what is different about this outreach area. You and I worked hard on getting the children's health plan in place, nothing the was extraordinarily disappointing to see the first year signup numbers. They were pathetic. Even after five years, they were pathetic. Even now, in Connecticut, with enormous resources dedicated to getting people into what we call Husky, still, in my hometown, with a Federal grant, with someone stationed in the emergency room, half of the, quote, uninsured were covered by either Medicaid or Husky.

So, this is quite a remarkable performance that such a huge percentage of our seniors are going to be signed up if they needed to be signed up by May 15. So, I hear what you are saying about the problems. There have been problems. I assume that you were very pleased with the Administrator's announcement about the policy governing formulary changes recently, which straightens out a lot of the problems and will give him a chance to set down new markers in the next round of contract requirements.

Mr. WAXMAN. I thought that was a good proposal to say that they could not take the drug off the formulary once people had signed up and were using that drug. There is no requirement that

is going to keep a plan from doing that. It is simply a guidance. There is nothing in statute to keep them from changing the policy later. Second, it does not deal with the price increases for those drugs.

Chairman JOHNSON OF CONNECTICUT. A point of note, though. The fact is that part of his announcement was that they have always had to come to CMS and inform CMS, but he made clear that CMS would only accept changes in the formulary where a new generic had come onto the market or safety concerns had been raised about a drug that was part of the formulary. So, it was not just that if you were on a drug you could continue taking it. It also very much changed the flexibility of the formulary during the calendar year.

Mr. WAXMAN. It did nothing about price increases. Once you sign up, and you get that drug, that drug can increase in price quite rapidly, which is, of course, a problem for seniors, and—

Chairman JOHNSON OF CONNECTICUT. I am sure my colleagues will have lots to say with you about the pricing. I wanted to limit my comments, because we do find that we really have to with so many Members stay within our 5 minutes, and as Chairman, I wanted to stay within my 5 minutes, and as Chairman, I wanted to stay within my 5 minutes. I agree with you there is a lot to be said about pricing and a lot to be said about the success of this program in lowering prices.

Mr. Stark.

Mr. STARK. Thank you, Madam Chair, and thank you very much, Henry, for being with us.

I want to ask kind of a type of inquiry that I know you will hate, and that is to ask you to be your own devil's advocate for a moment and explain, if you can, if you can take the other side, CMS seems to dispute some of your data on popular drug prices and the question of Costco being lower. Can you explain what their objection to your analysis is and why you think your data is the correct way to look at the prices in Part D?

Mr. WAXMAN. Well, there are some important differences between the CMS studies and our studies. Our pricing studies show that private Medicare drug plans are not obtaining good prices on the drugs used by beneficiaries and that other negotiators, like the Federal Government, could get much lower prices on the brand name drugs that account for the majority of drug costs.

One big difference between the studies is that the CMS study mixed together both brand name drugs and generics, and this made their price savings seem bigger than they actually are. The most important area where seniors need to save money is on expensive brand name drugs, and the Medicare plans just are not able to provide those savings.

Second, the CMS study inflates price savings by comparing Medicare drug plan prices to an inflated cash price that does not reflect what seniors are really paying at the pharmacy counter. Our study compares prices to four different benchmarks: the Federal negotiated VA price, the Canadian price, the prices at Costco and Drugstore.com. These comparisons show that Medicare plans are not obtaining the low prices. Finally, the CMS study takes into account

the impact of the Federal subsidy for all beneficiaries who sign up for the drug plans, which average about \$1,600 per beneficiary.

So, the CMS study shows that seniors save money when they take advantage of the subsidy, but it does not show that Medicare plans are negotiating low prices. There are other flaws with the CMS study as well. For example, it fails to take into account the fact that Medicare drug plans can and do raise prices at will, and our study shows that Medicare drug plans are not able to obtain low prices for seniors. The CMS study has so many differences and so many important flaws that I think it fails to address this issue.

Mr. STARK. Thank you very much.

Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Mr. Johnson.

Mr. JOHNSON OF TEXAS. Thank you, Madam Chairman.

Henry, can I quote you? You said—

Mr. WAXMAN. Well, you can. Are you able to?

Mr. JOHNSON OF TEXAS. Yes, I have it right here.

Certainly, there were people who were not covered before who are pleased to have new benefits. Certainly, we all welcome success stories, and we want this benefit to work. For too many seniors and persons with disabilities, it has not worked. It has been a disaster. I wonder how you can say that when 68 percent of the seniors in your district have signed up for this plan.

Further, you said drug prices under the new Medicare drug plans are too high, rising too fast. The Medicare drug bill was written to enrich the drug companies, not to provide seniors with a cost-effective, new benefit, and the Bush Administration mismanagement and incompetence has made the problem worse.

You know, with the number of seniors that have signed up in your district, I wonder if they think the prices are too high. I would suggest to you that our studies show that they have gone down, as a matter of fact, quite a bit from where we first estimated they will be.

Mr. WAXMAN. Well, Mr. Johnson, I do not know whether 68 percent of the people in my district have signed up or not, but the fact they signed up does not mean they are happy, or they are satisfied with this drug plan, especially for those people who signed up and then found out there were restrictions on the availability of drugs that they intentionally checked to be sure were on the plan's formulary. So, a lot of people have come to me and complained about that.

I look at this whole drug program, and I do not see savings. I see the plans not holding down the prices at all especially when you compare it to situations where the prices are held down, where the Government negotiates for the VA, and I am sure you are familiar with that, or even when the Government used to negotiate for the Medicaid program. Or you look at Costco.com, and when people shopped around there, they often got a better price than these plans are paying.

I am pleased that we have a step in the direction of a drug plan, but I think it is a flawed one, and I think we should learn from our experiences to see where we need to change this program, because the essential point of it is we were going to hold down drug prices through competition. There is no real market there. The

prices are not being held down. That means that seniors and the Government taxpayers are overpaying for drugs.

Mr. JOHNSON OF TEXAS. Well, in my district alone, there are 25 companies offering it, and they are competing against each other, and the prices are down. Maybe you ought to go back and take a look at your district again.

Thank you, Mr. Waxman.

Mr. WAXMAN. Thank you. Perhaps you want to look at yours again, too.

Mr. JOHNSON OF TEXAS. Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Mr. Doggett.

Mr. DOGGETT. You know, Mr. Waxman, thank you for your vital leadership.

As I listen to your description of the way this drug plan has worked versus the spokespersons for the Bush Administration yesterday and the opening statement of our Chairwoman, it is almost as if you were describing two entirely different worlds. I find that the world you are describing is the one that is what my seniors throughout Texas have been telling me, what a pharmacist in Mission, Texas is telling me about the problems that he encounters, and the very personal experience—my mom is 88 years old and seems to have kind of a pharmacy on her table when I go by to see her. My daughter, who is a physician, went to work to try to figure out which plan would work best. If she had gone with what appeared to be the best plan first, my mother would have been paying more for prescriptions than the huge price she was paying before this plan.

Finally, through a lengthy process that eventually involved consultation with my mother's various physicians, she has what she thinks is a savings for my mom, and even that may have been lost now that my mother has been switched to some additional prescriptions because she has some new problems.

I am confident that we can turn over this entire plan to sixth graders in Arkansas or Texas or California or Connecticut to punch in things. In fact, we can turn it over to preschool kids, and they will get people signed up. Many of them have more experience with computers than the seniors that I represent. It does not mean that they are going to get them a plan that saves them any money or meets their needs and addresses the problems that you have addressed.

Mr. WAXMAN. Well, Mr. Doggett, I would go to a sixth grader to learn to use my iPod or my computer, but I would not go to them to pick out an insurance plan.

Mr. DOGGETT. Well, I am sure that they can pick, but whether they pick one that will meet the concerns you have and will lower prices is quite a different question.

My concern has been not only the treatment of our seniors—I think some of them are being fleeced by this sort of plan—but that the taxpayer is being fleeced also. You remember the history that it took a great deal of deception from the Bush Administration, hiding the true numbers of the cost of this legislation, most of all from some of the Republicans who ended up voting it in the middle of the night when the rules were twisted here, and we were here all night long to force through this bill through the House.

Now, the fact that the Government is prohibited from negotiating on behalf of Medicare beneficiaries the way it does for our veterans through the VA means that ultimately, not only the seniors, but the taxpayers have to pay more.

Now, I raised this concern yesterday with Dr. McClellan, and he questioned the study that you have done that you reported on today, and though he said the VA program was great for veterans, he was unwilling to apply this same approach to help our seniors and to help American taxpayers get more cost benefit for their tax dollar. I just wonder if you might—I think you are familiar with this criticism of your average wholesale price analysis, if you might have any response to those criticisms of what I thought was a very important study that you and your staff have provided.

Mr. WAXMAN. The bottom line is that the survey by my staff showed that the Medicare plans were unable to adequately retain low prices for seniors. It is absurd that in the first few months of the program, prices went up 4 percent. Drug plans should not be allowed to increase prices on consumers after they sign up for the plan. They should not be allowed to pull a bait and switch on the consumers. It is good that they now are supposed to keep the drug on the formulary once someone is using it, but they should not allow the price to go up, and they certainly still allow that.

Medicare price increases are likely to continue. The latest estimate by CMS actuaries shows that they expect drug price increases under Medicare plans to be higher than the inflation rate for the next decade. Well, that is going to affect all seniors. The price increases reduce their purchasing power. They will use up their benefits, and they will enter the doughnut hole much faster than anticipated.

The statements by CMS yesterday were incorrect. My staff found that Medicare plan prices were going up faster than other benchmarks, but CMS said, well, not over the average wholesale price. If you look at the Canadian prices and other benchmarks, it is just clearly going up faster.

Mr. DOGGETT. Finally, you performed a great service in requesting this Government Accountability Office (GAO) study of the bureaucracy that is administering this complex plan. I think that showed that on the most important question of what is the best plan for you in terms of lowest cost that CMS was advising either incompletely, inaccurately, or no answer at all 60 percent of the time.

Mr. WAXMAN. Well, they not only gave inaccurate information to seniors, but they gave them to sixth graders who were advising the seniors.

[Laughter.]

Mr. WAXMAN. That makes me angry.

Mr. DOGGETT. Thank you.

Mr. WAXMAN. Thank you.

Chairman JOHNSON OF CONNECTICUT. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chairman.

You know, I have been here 16 years, and I really tried to work in a bipartisan, pragmatic way on issues. It is really disappointing to see—I understand politics. I have been around that world a long time. To politicize, as some are doing—I am not referring to the

witness nor to any of my colleagues necessarily, but I think to politicize the most important expansion of Medicare, the biggest entitlement since the Great Society programs I think is really unfortunate, and I think it does a disservice to this institution.

It is one thing to be critical of the program or the rollout. We can all be critical of the way dual eligibles were mishandled at the beginning, and I think corrections have been made. I think to cast it in political terms, Republicans versus Democrats, is really unfortunate. I hope we can get away from that and work more in a bipartisan way to see this program implemented so that it does benefit the seniors of America.

We are going to hear later from a witness, the Vice President of Ovation, which is a business unit of United Health Group, the only company, by the way, to currently offer the new Medicare prescription drug benefit in all 50 States and the District of Columbia. Since January 1, they have processed over 50 million prescription drug claims with beneficiaries yielding savings consistent—I am reading from their testimony now—consistent with CMS' estimate; \$1,100 per year, the average beneficiary is saving, that is, beneficiaries who, prior to the benefit, lacked prescription drug coverage, had no prescription drug coverage.

So, I think we have to recognize the pluses of this program, and I know that you have said, Mr. Waxman, previously, that the Government should implement a standard benefit—and this is a reasonable position—you said the Government should implement a standard benefit, with the premiums set at \$35 a month. Well, the latest estimates of the average premiums are \$25 a month under Part D.

Do you want to raise seniors' premiums? Is that what the \$35 figure suggests that you—

Mr. WAXMAN. No, I want a standard benefit. There is no guarantee that those premiums are going to stay low. They can go up much higher next year. Low premiums this year could be an enticement to get people to sign up in a plan by saying, oh, we are going to have a low premium for you.

Look: you are right. We have got what we have got, and I think the fair thing for people to do is to look at the facts. There are problems with this drug benefit. There are positive parts of it as well, but there are problems. For our colleagues to say what a great success it is is just not credible, because it is not a great success when we are hearing so many complaints and so many problems, partly from the rollout and quite a bit, I think, because of the way the whole program has been structured.

Mr. RAMSTAD. Well, I could take my remaining time and tell you of my constituents' success stories, those who have benefited significantly from it, people who were previously uninsured, and literally, as we have said around here many times, had to choose at the end of the month between putting food on the table and buying their necessary prescription drugs.

Mr. WAXMAN. That is why we need a drug plan, but let me just—

Mr. RAMSTAD. The low-income seniors have certainly benefited the most. That cannot be denied. Also, when I hear how drug costs have increased, it just does not—the empirical data suggests that

the top 20 drugs have all—the costs have come down as a result of this drug benefit, and we can show you that empirical data, so I think—

Mr. WAXMAN. I do not think you will be able—

Mr. RAMSTAD [continuing]. facts are stubborn things, and we are all entitled to our own opinions but not to our own facts.

Mr. WAXMAN. Right, that is why I do not think you will be able to establish that. I think you will see that the prices have gone up.

Mr. RAMSTAD. I will be glad to meet with you and share with you those figures.

Mr. WAXMAN. I also want to point out that CMS' own actuaries say that the premiums are going to increase by 28 percent, to \$32 next year. Well, plans can choose to go lower or higher. There is just no way to know what they are going to do. They are going to be under a lot of pressure unless they can hold down the price of drugs, and that is something we want them to be able to do.

Mr. RAMSTAD. Well, I certainly concur with that, and that is a key variable and a crucial variable. There is no question about that.

Well, with that, I appreciate your being here, Mr. Waxman, and yield back the balance of my time.

Chairman JOHNSON OF CONNECTICUT. Mr. English.

Mr. ENGLISH. Madam Chair, thank you for the offer of time, but I think I will yield back in order to allow this proceeding to move to its inevitable conclusion.

[Laughter.]

Chairman JOHNSON OF CONNECTICUT. Would the gentleman yield, Mr. English? If you are not going to use your time, there are a couple of things I did want to just put in the record.

Mr. ENGLISH. I would be delighted to yield.

Chairman JOHNSON OF CONNECTICUT. I do want to put in the record the fact that your study uses average wholesale prices, does it not?

Mr. WAXMAN. That is one of the benchmarks, but it also uses the Canadian prices, the VA prices, and the Drugstore.com prices. So, we have a number of benchmarks.

Chairman JOHNSON OF CONNECTICUT. I would just point out that the average wholesale prices are so irrelevant to the actual price of drugs that we have moved away from those to other kinds of pricing mechanisms to try to judge market prices and also by excluding—

Mr. WAXMAN. Well, we did not use it. That was the CMS criticism of it.

Chairman JOHNSON OF CONNECTICUT. Also, by excluding generics, you do not give anywhere near an accurate picture, because more than half of the prescriptions that seniors use are generics. Then, when you extol the VA, you sort of ignore the fact that 20 of the 33 prescription drugs that seniors most commonly use are not on the VA's formulary. Part of their low price structure is their limited formula range.

So, I wanted to put those facts on the table, but I will now recognize J.D. from Arizona.

Mr. HAYWORTH. Madam Chairman, if I could yield to my good friend from Missouri.

Chairman JOHNSON OF CONNECTICUT. Fine.

Mr. Hulshof from Missouri.

Mr. HULSHOF. Henry, if you will allow me to be so familiar.

Mr. WAXMAN. Kenny, do you want to have a beer and discuss this?

Mr. HULSHOF. Well, maybe we should. Actually, maybe we should adjourn and head down to, well, I probably should not name one of the lounges. I am obviously looking at my staff for guidance here as to where a local lounge would be.

[Laughter.]

Mr. WAXMAN. Well, we have our gym time coming up.

Mr. HULSHOF. In fact, here is the point, and I want to echo what my friend Jim Ramstad had to say. Somewhere in that answer to him, you acknowledged some positives. I think that is where, when I hear some of the incendiary rhetoric from some, I think we are talking past one another. Because we acknowledge—I will speak for myself; I acknowledge, as I did yesterday, there have been glitches. We have dealt with early on some complaints from senior citizens. We have tried to help walk them through. We have focused them to—we have a very good Division of Aging back in Missouri who has helped sign folks up.

I just wish there were more of an honest discussion about and acknowledgement that there are pluses and minuses, and so, that is an editorial comment you do not need to address.

I do want to mention one thing. Your critique of CMS, one of the critiques that you mentioned was that they include both brand names and generics in these positive numbers, and that is a criticism or a critique that you have made. Yet, you praised the VA for its formulary, and in fact, the VA formulary is predominantly generic and some brand name.

I point out that on the one hand, there is a critique because both brand name and generics are included, and yet, there is a lot of praise for the VA formulary when, in fact, it is more heavily tilted toward the generic. In fact, 20 of the top 33 drugs by seniors are not on the VA formulary.

The other concern I have as far as any sort of movement toward the VA, in Missouri, we have five VA pharmacies. We have 1,084 regular pharmacies. So, that is a concern.

Mr. WAXMAN. Can I just clarify?

Mr. HULSHOF. Sure, I will yield to you.

Mr. WAXMAN. I certainly want generic drugs to be substituted. They are the same drug as the brand name drug, and they should be substituted. We are not talking about trying to discourage the use of generics.

When they took brand name drugs and generics and put them together to show they were getting lower prices, it ignored the fact that 90 percent of the cost of the drugs for seniors is the brand name drugs. So, we have to look at the reductions in the prices of the drugs that cost the most.

The VA, for example, the VA does not restrict people's access to whatever drug they need. They encourage the generics, as they should, when there is one, but they do not deny, nor did Medicaid, but they do not deny access to the brand name drug you need when a generic is not available. We want that available to people. Yet,

they were able to hold the prices down, because they use the buying clout of the veterans to negotiate a lower price.

My problem is that we have foregone that, and I think that already, we are seeing this claim of a market holding down prices not working. If it does not work, then, we are going to have to look for some other alternatives.

Mr. HULSHOF. Well, the other side of the VA equation is that nonformulary prescriptions are approved by the VA only when the patient meets one of six very narrow tests, whether there is a contradiction to formulary drugs, adverse reaction, therapeutic failure, no formulary alternative exists, and number of these other areas.

Let me move on in the interests of time, and we have other witnesses coming. We can discuss and debate the CMS critique that you have, and yet, I think you also quoted the Medicare Trustees' Report, which came out earlier this week, and quite frankly, the Trustees' Report essentially says that program costs are down 20 percent; 15 percent of that savings is due to lower drug costs; and 5 percent savings due to plans, private plans, negotiating aggressively.

So, again, I do not want to talk past you, but I would hope that it is easy when you are back home, and if I wanted to have a town meeting, and I wanted to talk about ethanol, and I send a letter out to all the corn farmer constituent friends that I have, obviously, we are going to have a very pro-ethanol meeting, and if I have been talking about a flawed program and confusing scheme, and if I have been vehemently opposed to a prescription drug benefit, and if I wanted to call a town meeting and send out a mailing, of course, I am going to have people who are quite critical of the program.

Again, that is not a comment on you or any of your testimony, and I appreciate your prejudice.

Mr. WAXMAN. Well, that is a good point that you make. In other words, you are saying if we are criticizing the plan at a town meeting, people will get a negative view of it. I do not think they really need us to criticize it for them to get that negative view, because they feel they were promised a drug benefit under Medicare, like they get doctors paid by Medicare, they get the hospitals, they get the physical therapists all paid. It is a benefit, and it is covered.

I think it is as if you went in to buy a Lexus, and they gave you a clunker. It is better to have a clunker than nothing, but you feel a little let down that you did not get what you thought you were being promised.

Chairman JOHNSON OF CONNECTICUT. Mr. Rangel.

Mr. RANGEL. Thank you so much for the courtesy, Madam Chairlady.

When you inquired of Mr. Waxman of the number of people who had enrolled into this program and said it was 68, I was amazed at that number based on how bad I am doing in my district, so I asked staff to see whether they could get from CMS the same type of material and found out they had 76 for my district.

So, then, I read it further, and I find out that not only do I have 76, but they expect to increase that to 107 percent. In some districts, they expected 112 percent. So, knowing that meant the num-

bers were padded, I just want to figure out how did they get the 76 percent? Being honest, as the Administration normally is, they included all sources, which meant that anybody who had any coverage of any kind, including retirees or those that are dual beneficiaries that were forced to go into the program because it was Medicaid, they were pushed into this.

So, in fact, this number has very little to do with those who have enrolled. It means those who have coverage. Then, looking up here, it really said that: Medicare beneficiaries with prescription drugs coverage, which has absolutely nothing to do with the prescription drug program that is Part D. So, I know the staff probably overlooked that, but I just wanted Henry to know things are not any better than you thought they were.

Mr. WAXMAN. Mr. Rangel, if I could say something about Medicaid, which is in the jurisdiction of the Energy and Commerce Committee—

Mr. RANGEL. Oh.

Mr. WAXMAN. Used to be in your jurisdiction, and who knows what the future will be?

The fact of the matter is the people under Medicaid had—they knew they got their drugs covered. It was being paid for under the Medicaid program, and it was also being paid for at the lowest price, because the States and the Federal Government negotiated and got that lower price. They insisted on the best price; there were rebates.

So, we took them away from the Medicaid programs and shifted it over to Medicare. So, we do not have those negotiated lower prices anymore. So, we are paying more for the Medicaid and Medicare dual eligibles, for their drugs, and they have less of a certainty that their drugs are even going to be covered.

That cannot be a good deal. Now, I do not want to be only negative about it, but that is not a good deal. If you think about it for a minute, if you are somebody who needs a certain drug, and you check with a 6-year-old or sixth-grader, and the sixth-grader says that your drug for high blood pressure, or let us say it is an antipsychotic drug is on the formulary, and you sign up with that drug plan to be sure you get that drug, and then, after you sign up, they tell you, oh, by the way, you cannot get that drug; you have to use another drug. Then, if that drug does not work therapeutically, then, you could step up.

Well, they have already gone through this. To tell somebody, let us say, who needs an antipsychotic drug that they cannot get the one that is working for them any longer, you could see how angry they could be, not just because they did not have their drugs to calm them down.

[Laughter.]

Mr. WAXMAN. They would be angry because they thought they were signing up in a plan that was going to give them the drug.

So, anyway, I think there are real problems in this. We ought to be mindful, all of us, Democrats and Republicans, of what is working and what is not and then address the problems where the program is not working, because we owe it to the American people to do better.

Mr. RANGEL. Well, even though the Medicaid people are paying more under the Part D, and even though the dual beneficiaries pay more than they would normally pay, at least you know that they should be on it; that they are included as new enrollees in the plan.

Mr. WAXMAN. Well, we are paying more for them, because Medicaid beneficiaries do not pay those co-pays.

Mr. RANGEL. Based on your experience, could you give us one reason why the Government would not want Medicare to be able to negotiate the same way the VA does? To what advantage would be to the taxpayer and to the beneficiaries not to be able to negotiate and to get the lowest possible price?

Mr. WAXMAN. Every insurance plan that covers pharmaceuticals negotiates for better prices using their buying clout. What we have done is lost the opportunity to have the Government negotiate those better prices. The only thing I can say in answer to you is that some people believed in this market theory. They think it is going to work, and I do not think it is going to work. The second reason is that the pharmaceutical companies did not want Medicare negotiating, because they were going to have to take less money, and there were a lot of people who did not want to disappoint the pharmaceutical companies.

In fact, two of the people involved in the negotiation of the Medicare bill went off to work for the pharmaceutical companies. So, I think for those two reasons, I think it is unfortunate that we gave up the ability of the Government to negotiate good prices for the buying clout of seniors.

Mr. RANGEL. There is a clear implication that the Congress, at least that part that controlled the Congress, wanted to do what was best for the pharmaceuticals rather than the beneficiaries.

Mr. WAXMAN. Sad.

Mr. RANGEL. Thank you, Madam Chairlady.

Chairman JOHNSON OF CONNECTICUT. You are welcome.

Given that people who have planes to catch, we are going to move on to the next panel, but Henry, since you are on the Commerce Committee and an advocate of the best price laws to give Medicaid the best price, you should be aware of testimony we had yesterday from a national insurer saying that they had been able to negotiate prices below the best prices in the State, because we in the Medicare law allowed the circumvention of that.

So, the prices are very low. You can see that in the State payment programs. They are going to make more on this program than they anticipated, because their prices were higher than ours, and so, there are many ways in which everybody is going to benefit, and it is too bad that we cannot go back and forth about the details, but we do have another panel, and we need to get on to them.

Mr. WAXMAN. Nancy, put me down as skeptical, because even the drug companies have suggested their prices are going to be higher. We will disagree on that.

Chairman JOHNSON OF CONNECTICUT. Well, I see in your other statements that you are not out there saying that your members should not sign up. Your members should sign up, and you have said that very clearly.

Mr. WAXMAN. Also, we ought to extend the deadline.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Chairman JOHNSON OF CONNECTICUT. Next panel.

As the next panel gathers, since for most of you, your testimony was in the record yesterday as you submitted it, would you please focus on any additions to that this, so hopefully, we can get through your testimony before Members have to leave to catch their planes?

We have with us on this next panel, we have Leslie Aronovitz of the GAO; Vicki Gottlich of the Center for Medicare Advocacy; Mark Steinberg, Senior Health Policy Analyst at Families, USA; and Joyce Larkin, Vice President, Public Affairs and Community Relations at Ovations of United Health Group; and Bill Vaughan, Senior Policy Analyst at Consumers Union.

We will start with Leslie Aronovitz.

**STATEMENT OF LESLIE ARONOVITZ, U.S. GOVERNMENT
ACCOUNTABILITY OFFICE**

Ms. ARONOVITZ. Thank you, Madam Chairman and Members of the Subcommittee. I am pleased to be here today as you discuss the Centers for Medicare and Medicaid Services' implementation of the Medicare Part D outpatient drug benefit.

Given the newness and complexity of the Part D benefit, it is critical that beneficiaries and those who advise them on health care decisions understand how Part D works and the options available. As part of its responsibilities, CMS provides beneficiaries and their advisors with information about Part D through various media, including written documents, the 1-800-Medicare help line, and the Medicare Website.

In our report released yesterday, we evaluated the readability of a sample of CMS' written documents, the accuracy and responsiveness of CMS' 1-800-Medicare help line, and the usability of the Part D portion of CMS's Medicare Website.

In summary, the written documents we reviewed were largely complete and accurate, but the way the information was presented made comprehension difficult. According to our contractor that has expertise in preparing written materials for seniors, about 40 percent of seniors read at or below the fifth grade level. However, we found that the reading levels for our sample documents ranged from seventh grade to post college, and once adjusted for words that CMS cannot replace with easier words, it still ranged from about eighth grade to twelfth grade level.

Also, on average, we found that the six documents did not comply with about half of the commonly recognized guidelines for good communications. For example, although the documents included concise and descriptive headings, they used too much technical jargon and often did not define difficult terms.

In regard to the 500 calls we made to CMS' 1-800-Medicare help line, 67 percent of the calls were answered accurately and completely; 3 percent were answered incompletely; 18 percent inaccurately; and 8 percent were answered inappropriately given the question that was asked, and I can elaborate on that later. Five percent of our calls were not answered, primarily because we were disconnected.

I would like to note that these accuracy and completeness rates varied significantly across the questions we asked. For example, for

the question on whether a beneficiary qualifies for extra help, customer service representatives (CSRs) provided an accurate and complete response 90 percent of the time. The correct answer would have been to call the Social Security Administration to find out about extra help.

However, for a question concerning which drug plan is the least costly for a beneficiary with certain specified prescription drug needs, the accuracy rate was 41 percent. In 35 percent of our calls for that question, CSRs inappropriately responded that this question could not be answered without personal identifying information, such as the beneficiary's Medicare number or date of birth, even though some CSRs answered our questions using CMS' Web-based prescription drug plan finder tool, which was the appropriate tool to use.

Sometimes, we experienced extensive wait times before we could speak to a CSR. For 75 percent of the 477 calls where we reached a CSR—23, we did not, because we were disconnected—we waited less than 5 minutes. So, most of the time, we waited less than 5 minutes. Thirteen percent of the time, the calls were answered in between 5 and 15 minutes; 8 percent of the time, they were answered in 15 to 25 minutes; and about 5 percent of the time, we waited more than 25 minutes.

Finally, in regard to the Medicare Website, we engaged a contractor with expertise in evaluating Websites, including those used by seniors. We concluded that the Part D portion of Medicare.gov can be difficult for some to navigate. In overall usability tests, the site scored 47 percent for seniors and 53 percent for younger adults. Use of tools such as the Drug Plan Finder was daunting, and online forms that collect information from users were difficult to correct if the user made an error.

Further, in the evaluation of 137 detailed aspects of a Website, we found that 70 percent of these aspects could be expected to cause users confusion. For example, key functions of the drug plan finder tool, such as the continue button or the choose a drug plan button, were often not visible on the screen unless you scrolled down.

Chairman JOHNSON OF CONNECTICUT. Would you suspend for a moment?

Ms. ARONOVITZ. Sure.

Chairman JOHNSON OF CONNECTICUT. I forgot to remind the witnesses that we do have 5 minutes per witness. You have reached your 5 minutes, but if you could just wrap up with a sentence, I am sure that in questions, we will give you an opportunity to conclude your statement.

Ms. ARONOVITZ. I would be happy to.

Chairman JOHNSON OF CONNECTICUT. Because people have planes to catch, I do want to observe the five-minute rule on the podiums as I have for the Members.

Ms. ARONOVITZ. Absolutely.

It should be noted that given the complexity of the benefit and the time allocated for implementation, CMS did face a tremendous challenge in developing its communication efforts, and we look forward to working with CMS as it continues to refine its communication tools to better serve the public.

This concludes my statement, and I am happy to answer any questions.

[The prepared statement of Ms. Aronovitz follows:]

**Prepared Statement of Leslie Aronovitz, Director for Healthcare,
U.S. Government Accountability Office**

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the Medicare outpatient prescription drug benefit, known as the Part D benefit, which was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003¹ with coverage beginning on January 1, 2006. Until this time, Medicare, the program that finances health care benefits for about 42 million elderly and disabled beneficiaries, had not generally provided coverage for outpatient prescription drugs. Beneficiaries who opt to enroll in Part D may choose a drug plan from those offered by private plan sponsors under contract to the Centers for Medicare & Medicaid Services (CMS), which administers the Part D benefit. These plans differ in the drugs covered, pharmacies used, and enrollee costs. As of April 20, 2006, more than 30 million of Medicare's 42 million beneficiaries were enrolled in a Part D plan or had other outpatient prescription drug coverage. Beneficiaries have until the end of the current enrollment period, May 15, 2006, to enroll in the Part D benefit and select a plan without the risk of penalties in the form of higher premiums.

Given the newness and complexity of the Part D benefit, it is critical that beneficiaries and their advisers, including members of their families, understand the options available to them. Understanding these options enables beneficiaries to make informed decisions on whether to enroll in the Part D benefit, and if they decide to enroll, which drug plan to choose. As part of its responsibilities, CMS has undertaken efforts to provide beneficiaries and their advisers with the information they need about the Part D benefit through various media, including written documents, the 1-800-MEDICARE help line,² and the Medicare Web site.³ CMS's education efforts are important because widespread confusion has been reported among beneficiaries about the costs and coverage under the new benefit.

You and others have expressed interest in ensuring that Medicare beneficiaries receive the information they need to make informed decisions. My remarks today will focus on (1) the extent to which CMS's written documents describe the Part D benefit in a clear, complete, and accurate manner; (2) the effectiveness of CMS's 1-800-MEDICARE help line in providing accurate, complete, and prompt responses to callers inquiring about the Part D benefit; and (3) whether CMS's Medicare Web site presents information on the Part D benefit in a usable manner. My testimony will summarize findings of a report we released yesterday that examines CMS's Medicare Part D benefit communications to beneficiaries in more detail and includes recommendations to the CMS Administrator for improving the quality of the agency's Part D benefit education and outreach materials.⁴

To address these issues, we interviewed CMS officials responsible for written documents about the Part D benefit, the 1-800-MEDICARE help line, and the Medicare Web site. To assess the clarity, completeness, and accuracy of written documents, we performed an in-depth review of a sample of six CMS documents describing the Part D benefit, including contracting with the American Institutes for Research (AIR), a firm with experience in evaluating written documents, to assess their clarity. (See app. I for a list of written documents reviewed.) We also placed 500 calls to 1-800-MEDICARE, posing one of five questions related to the Part D benefit in each call so that each question was asked 100 times. We evaluated the accuracy and completeness of customer service representatives' (CSR) responses to these questions. (See app. II for the questions and criteria we used to evaluate the accuracy and completeness of CSR responses to calls we made to 1-800-MEDICARE.) To assess the usability of the Part D benefit information available on the Medicare Web site, we contracted with the Nielsen Norman Group (NN/g), an expert

¹ Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-2152 (to be codified at 42 U.S.C. §§ 1395w-101-1395w-152). The MMA redesignated the previous Part D of Title XVIII of the Social Security Act as Part E and inserted a new Part D after Part C.

² In December 2004, we reported on the information being provided to beneficiaries through the Medicare help line on eligibility, enrollment, and benefits. See GAO, Medicare: Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved, *GAO-05-130* (Washington, D.C.: Dec. 8, 2004).

³ The Medicare Web site is www.medicare.gov.

⁴ GAO, Medicare: Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved, *GAO-06-654* (Washington, D.C.: May 3, 2006).

on Web design. We conducted our work from November 2005 through May 2006, in accordance with generally accepted government auditing standards.

In summary, CMS successfully developed a large volume of information about the new Part D benefit and made it available to beneficiaries through a variety of sources, despite the challenge of developing this information within a short time frame. However, the quality of CMS's communications to beneficiaries and their advisers about the Part D benefit could be improved. For example, although the six CMS written documents we reviewed were largely accurate and complete, they often lacked clarity. Specifically, while about 40 percent of seniors read at or below the fifth-grade level, the reading levels of the documents ranged from seventh grade to postcollege. Moreover, the six documents used too much technical jargon and often did not define difficult terms. Similarly, although 67 percent of the responses to the 500 calls we placed to CMS's 1-800-MEDICARE help line regarding the Part D benefit were accurate and complete, we nonetheless received a substantial number of responses that were not. Eighteen percent of the calls received inaccurate responses, 8 percent of the responses were inappropriate given the question asked, about 3 percent received incomplete responses, and about 5 percent of our calls were not answered, primarily due to disconnections.⁵ In addition, our review of the Part D benefit portion of the Medicare Web site showed that this site can be difficult to use. In usability tests that examined the ease of finding needed information and performing various tasks, we found that, for overall usability, the Web site scored 47 percent for seniors and 53 percent for younger adults, out of a possible 100 percent. While there is no widely accepted benchmark for usability, these scores indicate that using the site can be difficult. Therefore, in the report we issued yesterday, we made specific recommendations to the CMS Administrator to enhance the quality of the agency's communications on the Part D benefit, including clarifying written materials, monitoring the accuracy and completeness of CSR's responses to callers' inquiries, and improving the usability of the Part D benefit portion of the Medicare Web site. In its comments on a draft of our report (see app. III), CMS said that it supports the goals of our recommendations and is already taking steps to implement them. However, CMS said that our findings did not present a complete and accurate picture of its Part D benefit communications activities. We believe that our report provides an accurate examination of the CMS communications mechanisms that have the greatest impact on beneficiaries (see app. IV).

Background

CMS has undertaken steps to educate beneficiaries about the Part D benefit using written documents, a toll-free help line, and the Medicare Web site. To explain the Part D benefit to beneficiaries, CMS had produced more than 70 written documents as of December 2005. *Medicare & You*—the beneficiary handbook—is the most widely available and was sent directly to beneficiaries in October 2005. Other written documents were targeted to specific groups of beneficiaries, such as dual-eligible beneficiaries⁶ and beneficiaries with Medicare Advantage or Medigap policies.⁷

Beneficiaries can obtain answers to questions about the Part D benefit by calling the 1-800-MEDICARE help line. This help line, which is administered by CMS, was established in March 1999 to answer beneficiaries' questions about the Medicare program. As of December 2005, about 7,500 CSRs were handling calls on the help line, which operates 24 hours a day, 7 days a week, and is run by two CMS contractors. CMS provides CSRs with detailed scripts to use in answering the questions. Call center contractors write the scripts, and CMS checks them for accuracy and completeness.

In addition, CMS's Medicare Web site provides information about various aspects of the Medicare program. The Web site contains basic information about the Part D benefit, suggests factors for beneficiaries to consider when choosing plans and provides guidance on enrollment and plan selection. It also lists frequently asked questions and allows users to view, print, or order publications. In addition, the site contains information on cost and coverage of individual plans. There is also a tool that allows beneficiaries to enroll directly in the plan they have chosen.

⁵The percentages related to the responses we received to our 500 calls exceed 100 percent due to rounding.

⁶Dual-eligible beneficiaries are Medicare beneficiaries who are also eligible for Medicaid—the federal-state health program for low-income individuals—and receive full Medicaid benefits for services not covered by Medicare.

⁷Medicare Advantage replaced the Medicare+Choice managed care program and expanded the availability of private health plan options to Medicare beneficiaries. Medigap policies provide supplemental health coverage sold by private insurers to help pay for Medicare cost-sharing requirements, as well as for some services not provided by Medicare.

Clarity of CMS Written Documents Could Be Improved

Although the six sample documents we reviewed informed readers of enrollment steps and factors affecting coverage, they lacked clarity in two ways. First, about 40 percent of seniors read at or below the fifth-grade level, but the reading levels of the documents ranged from seventh grade to postcollege. As a result, these documents are challenging for many seniors. Even after adjusting the text for 26 multisyllabic words, such as Medicare, Medicare Advantage, and Social Security Administration, the estimated reading level ranged from seventh to twelfth grade, a reading level that would remain challenging for at least 40 percent of seniors.

Second, on average, the six documents we reviewed did not comply with about half of the 60 commonly recognized guidelines for good communications. For example, although the documents included concise and descriptive headings, they used too much technical jargon and often did not define difficult terms such as formulary.⁸ The 11 beneficiaries and 5 advisers we tested reported frustration with the documents' lack of clarity as they encountered difficulties in understanding and attempting to complete 18 specified tasks. For example, none of these beneficiaries and only 2 of the advisers were able to complete the task of computing their projected total out-of-pocket costs for a plan that provided Part D standard coverage. Only one of 18 specified tasks was completed by all beneficiaries and advisers. Even those who were able to complete a given task expressed confusion as they worked to comprehend the relevant text.

Help Line Responses Frequently Complete and Accurate, but Varied By Question

Of the 500 calls we placed to CMS's 1-800-MEDICARE help line regarding the Part D benefit, CSRs answered about 67 percent of the calls accurately and completely. Of the remainder, 18 percent of the calls received inaccurate responses, 8 percent of the responses were inappropriate given the question asked, and about 3 percent received incomplete responses. In addition, about 5 percent of our calls were not answered, primarily because of disconnections.⁹

The accuracy and completeness of CSR responses varied significantly across our five questions. (See fig. 1.) For example, while CSRs provided accurate and complete responses to calls about beneficiaries' eligibility for financial assistance 90 percent of the time, the accuracy rate for calls concerning the drug plan that would cost the least for a beneficiary with specified prescription drug needs was 41 percent. CSRs inappropriately responded 35 percent of the time that this question could not be answered without personal identifying information—such as the beneficiary's Medicare number or date of birth—even though the CSRs could have answered our question using CMS's Web-based prescription drug plan finder tool. CSRs' failure to read the correct script also contributed to inaccurate responses. The time GAO callers waited to speak with CSRs also varied, ranging from no wait time to over 55 minutes. For 75 percent of the calls—374 of the 500—the wait was less than 5 minutes.

⁸A formulary is a list of prescription drugs covered by a health plan.

⁹The percentages related to the responses we received to our 500 calls exceed 100 percent because of rounding.

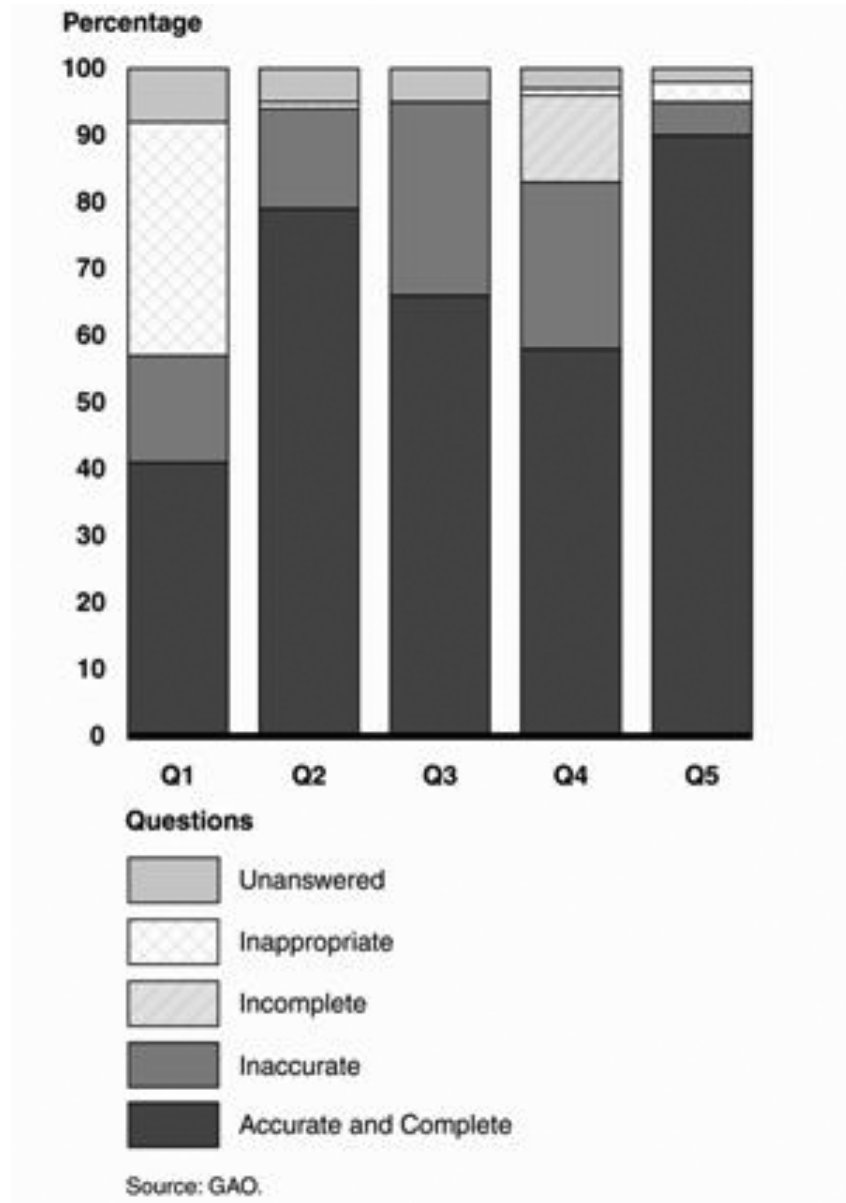


Figure 1: Variation in CSRs' Responses for Individual Questions

Part D Benefit Portion of Medicare Web Site Can Be Challenging to Use

We found that the Part D benefit portion of the Medicare Web site can be difficult to use. In our evaluation of overall usability—the ease of finding needed information and performing various tasks—we found usability scores of 47 percent for seniors and 53 percent for younger adults, out of a possible 100 percent. While there is no widely accepted benchmark for usability, these scores indicate difficulties in using the site. For example, tools such as the drug plan finder were complicated to use,

and forms that collect information on-line from users were difficult to correct if the user made an error.

We also evaluated the usability of 137 detailed aspects of the Part D benefit portion of the site, including features of Web design and on-line tools, and found that 70 percent of these aspects could be expected to cause users confusion. For example, key functions of the prescription drug plan finder tool, such as the “continue” and “choose a drug plan” buttons, were often not visible on the page without scrolling down. In addition, the drug plan finder tool defaults—or is automatically reset—to generic drugs, which may complicate users’ search for drug plans covering brand name drugs. The material in this portion of the Web site is written at the 11th grade level, which can also present challenges to some users. Finally, in our evaluation of the ability of seven participants to collectively complete 34 user tests, we found that on average, participants were only able to proceed slightly more than half way through each test. When asked about their experiences with using the Web site, the seven participants, on average, indicated high levels of frustration and low levels of satisfaction.

Concluding Observations

Within the past 6 months, millions of Medicare beneficiaries have been making important decisions about their prescription drug coverage and have needed access to information about the new Part D benefit to make appropriate choices. CMS faced a tremendous challenge in responding to this need and, within short time frames, developed a range of outreach and educational materials to inform beneficiaries and their advisers about the Part D benefit. To disseminate these materials, CMS largely added information to existing resources, including written documents, such as *Medicare & You*; the 1-800-MEDICARE help line; and the Medicare Web site. However, CMS has not ensured that its communications to beneficiaries and their advisers are provided in a manner that is consistently clear, complete, accurate, and usable. Although the initial enrollment period for the Part D benefit will end on May 15, 2006, CMS will continue to play a pivotal role in providing beneficiaries with information about the drug benefit in the future. The recommendations we have made would help CMS to ensure that beneficiaries and their advisers are prepared when deciding whether to enroll in the benefit, and if enrolling, which drug plan to choose.

Mr. Chairman, this concludes my prepared remarks. I would be happy to respond to any questions that you or other Members of the subcommittee may have at this time.

Appendix I: Sample of CMS Written Documents Reviewed

To assess the clarity, completeness, and accuracy of written documents, we compiled a list of all available CMS-issued Part D benefit publications intended to inform beneficiaries and their advisers and selected a sample of 6 from the 70 CMS documents available, as of December 7, 2005, for in-depth review, as shown in Table 1. The sample documents were chosen to represent a variety of publication types, such as frequently asked questions and fact sheets available to beneficiaries about the Part D benefit. We selected documents that targeted all beneficiaries or those with unique drug coverage concerns, such as dual-eligibles and beneficiaries with Medigap plans.

Table 1: Sample of Six Selected Documents

Document	Target audience
<i>Medicare & You</i> , Section 6: Medicare Prescription Drug Coverage	All beneficiaries
<i>Things to Think about When You Compare Plans</i>	All beneficiaries
<i>Frequently Asked Questions about: Retiree Prescription Drug Coverage & the New Medicare Prescription Drug Coverage</i>	Beneficiaries with employer or union coverage
Introduction to the Auto-Enrollment Notice	Dual-eligible beneficiaries ^a

Table 1: Sample of Six Selected Documents—Continued

Document	Target audience
<i>Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare Health Plan with Prescription Drug Coverage</i>	Beneficiaries with Medicare Advantage ^b
<i>Do You Have a Medigap Policy with Prescription Drug Coverage?</i>	Beneficiaries with Medigap ^c

Source: GAO.

^aDual-eligible beneficiaries are Medicare beneficiaries who receive full Medicaid benefits for services not covered by Medicare.

^bMedicare Advantage replaced the Medicare + Choice managed care program and expanded the availability of private health plan options to Medicare beneficiaries.

^cMedigap policies provide supplemental health coverage sold by private insurers to help pay for Medicare cost-sharing requirements, as well as for some services not provided by Medicare.

Appendix II: Questions and Criteria Used to Evaluate Accuracy and Completeness of CSR's Help Line Responses

To determine the accuracy and completeness of information provided regarding the Part D benefit, we placed a total of 500 calls to the 1-800-MEDICARE help line. We posed one of five questions about the Part D benefit in each call, so that each question was asked 100 times. Table 2 summarizes the questions we asked and the criteria we used to evaluate the accuracy of responses.

Table 2: Questions and Criteria Used to Evaluate Accuracy and Completeness

Question GAO Asked MEDICARE help line CSRs	Criteria GAO used to evaluate accuracy and completeness of CSR Responses
1. What drug plan can a beneficiary get that will cover all of his/her [specified] drugs at a [specified] pharmacy, have a mail-order option; and cost the least amount annually with [or without] a deductible?	An accurate and complete response would identify the prescription drug plan that has the lowest estimated annual cost for the drugs the beneficiary uses.
2. Can a beneficiary who is in a nursing home and not on Medicaid sign up for a prescription drug plan?	An accurate and complete response would indicate that a beneficiary can choose whether to enroll in a Medicare prescription drug plan.
3. Can a beneficiary enroll in the Medicare prescription drug program and keep his/her current Medigap policy?	An accurate and complete response would inform the caller that enrolling for the prescription drug benefit would depend on whether the beneficiary's Medigap plan was creditable—that is, whether the coverage it provided was at least as good as Medicare's standard prescription drug coverage—or non-creditable. The CSR response would also mention that the beneficiary's Medigap plan should have sent him/her information that outlined options.
4. What options does a beneficiary, who has retiree health insurance with prescription drug coverage that is not as good as the Medicare prescription drug coverage, have as it relates to the Medicare benefit?	An accurate and complete response would indicate that a beneficiary has two options: (1) keep current health plan and join the prescription drug plan later with a penalty, or (2) drop current coverage and join a Medicare drug plan.

Table 2: Questions and Criteria Used to Evaluate Accuracy and Completeness—Continued

Question GAO Asked MEDICARE help line CSRs	Criteria GAO used to evaluate accuracy and completeness of CSR Responses
5. How do I know if a beneficiary qualifies for financial assistance?	An accurate and complete response would refer the beneficiary to the Social Security Administration.

Source: GAO.

Appendix III: Comments from the Centers for Medicare & Medicaid's Services

DATE: May 1, 2006
TO: Leslie G. Aronovitz
 Director, Health Care
FROM: Mark B. McClellan, M.D., Ph.D.
 Administrator
SUBJECT: Government Accountability Office's (GAO) Draft report, "*MEDICARE: Communications to the Beneficiaries on the Prescription Drug Benefit Could Be Improved*" (GAO-06-654)

The Centers for Medicare & Medicaid Services has reviewed the findings in the GAO report entitled *MEDICARE: Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved* (GAO-06-654) regarding CMS communications on the Part D benefit. Having clear and effective communication about Medicare's new prescription drug coverage is one of the Agency's critical priorities. We have worked very hard to ensure that Medicare beneficiaries have the information they need to make decisions about enrolling in a drug plan that works for them. We are pleased that the millions of beneficiaries who have enrolled in Part D are experiencing very high rates of satisfaction with their coverage. Each week, tens of thousands of beneficiaries are enrolling in Part D, which gives them real savings and protections for the future.

While we greatly appreciate the feedback from your report and have already worked to implement your recommendations, we do not believe that your findings present a complete or accurate picture of the Part D communication activities. We understand that the report is based on studies of particular aspects of some of our communications tools at one point in time three months ago, in January and early February 2006. In addition to the many "continuous improvement" activities we have undertaken to address startup issues in the drug benefit since that time, there are much more extensive internal and external evaluations of our communications activities completed before, during, and after that time which have different conclusions, as we note below. These evaluations have used well-established methods which have been clearly documented and reviewed; in contrast, you have not yet responded to our requests for information on the methods you have applied. Additionally, your report does not address the unique breadth and depth of CMS activities to educate and to reach out to people with Medicare and the community that supports them in their health care decisions. From the outset, it was clear that no single source of information would be adequate or preferred by all of our beneficiaries. Consequently, we have expanded the range of tools available and vastly expanded our local partnerships to help beneficiaries use them, partnering with more than ten thousand diverse public and private organizations around the country in this effort.

Importantly, the report does not look at this broad array of communication tools to help Medicare beneficiaries consider their drug plan options. For example, the report dismisses all of the tools used by our customer service representatives and our website for beneficiaries that provide personalized identifying information to enable us to provide them with personally customized service. The vast majority of our callers provide such personal identification, yet these tools were not evaluated. In fact, the report misleadingly states that we provided the right information on a lower share of cases because some customer service representatives sought to get this personal information to serve the beneficiary more quickly and effectively. Where GAO did actually get information on drug costs, as thousands of callers get every day, customer service representatives provided accurate information at a much higher rate. As another example, GAO evaluated whether beneficiaries could calculate their

out-of-pocket drug costs in the standard Medicare benefit by hand, using only the *Medicare and You* handbook, but very few beneficiaries have opted to use the handbook in this way because: (1) there are far better tools available for quickly and automatically calculating drug costs on the web, on the phone, and through our partner organizations, and (2) over 90 percent of our beneficiaries are choosing plans with benefits other than the standard plan, because they prefer features like zero deductibles, flat copays, and coverage in the “donut hole.” Beneficiaries are overwhelmingly using other tools to make effective cost comparisons.

In fact, the drug plan finder element of the website has received 164.6 million page views between November 15, 2005 and April 26, 2006. The Frequently Asked Questions (FAQ) section of www.medicare.gov has been accessed more than one million times since January 1, 2006. CMS has also responded to more than 19,000 emails received through the FAQ section, with 93% of them being resolved satisfactorily in the first response.

Finally, there is no attention in the report at all to major aspects of our communications activities and expenditures, such as the expansion of our community based education and outreach efforts through an extensive network of grassroots partners across the country. This significant emphasis on reaching people where they live, work, play and pray is a key component of our success in reaching millions of people with Medicare and those who work on their behalf. No mention is made of the specialized campaigns targeting African American, Hispanic, American Indians, Asian American and Pacific Islander and in low income communities. These campaigns utilize new partnerships, employ materials in other languages and specialized paid media campaigns. These targeted campaigns within the broader campaign allow us to reach all segments of the Medicare population, including those who might benefit from the low income subsidy and those with language and other cultural barriers to accessing information.

We believe that there have been a number of key elements to our successful education campaign. First, we recognized early on that we would need to supplement our proven traditional communications tools, including the Medicare & You Handbook, the 1-800-MEDICARE line, and the State Health Insurance Assistance Programs (SHIPs) with additional advanced technology and grassroots resources, as well as use earned and paid media opportunities. Second, we determined that the provision of personalized assistance and one-on-one counseling was the key ingredient to success. This necessitated our building a grassroots network of traditional and non-traditional partners who were willing to be trained to provide the one-on-one counseling. We strongly believe this is important for beneficiaries to make confident decisions about their Part D plan. We knew we would have to develop a grassroots capacity and local networks to supplement the CMS regional structure to provide the necessary education and enrollment assistance at the community level. This would involve reaching out, not just to our traditional partners such as the SHIPs, but to all the groups and organizations that have contact with our beneficiaries on a daily basis “where they work, where they play, and where they pray.”

We appreciate any and all ideas for improving our communications efforts, and we take very seriously the four tasks that GAO recommends to improve CMS’ education efforts. We support the goal of these tasks and have already taken many steps to meet them.

Ensure that CMS’s written documents describe the Part D benefit in a manner that is consistent with commonly recognized communications guidelines and that is responsive to the intended audience needs.—CMS employs a wide variety of consumer research techniques, simple language best practices, and independent evaluations in both English and in Spanish documents to ensure the readability and usefulness of our educational materials including those describing Part D. These tests have demonstrated that CMS written documents follow best practice guidelines for written communications with the intended audiences. These techniques and practices are summarized in Attachment A. Because of the importance of this topic, we are always interested in improving our written products. We look forward to an opportunity to review what GAO used in its review and will compare them to the evaluation methods we are already using, as soon as GAO is willing to provide the methodological details.

Determine why CSRs frequently do not search for available drug plans if the caller does not provide personal identifying information.—As discussed with the GAO reviewers, CMS has instructed CSRs, in cases where that information is unavailable, to perform a search that provides general information on the plan options available to the beneficiary. Our web tools have always been set up to support such “unauthenticated” searches as well.

1-800 MEDICARE CSRs do have the ability to conduct a general search for callers who do not have their Medicare number. If the person provides personal infor-

mation, the authenticated search, other information that may influence their decision is pulled into the search, e.g., low income subsidy status or coverage through a retiree drug subsidy. Because this path provides more robust and specific results, CMS has encouraged CSRs to stress the importance of an authenticated Prescription Drug Plan Finder search to callers. The importance of authenticated searches is stressed in the CSR training materials and scripts. We have placed warnings throughout the training materials about the downside of proceeding without the personalized information and CSRs do suggest that the person call back when they have it.

Even so, we know that there are occasions in which someone may not want to provide this information, or another caller may be inquiring on behalf of a beneficiary and not have the information, or a reporter or analyst may be calling for information. It has been emphasized to CSRs that non-authenticated general information is to be shared if the caller is unable to provide specific information that would enable a more detailed search. An example of relevant CSR instructions follows. "If a caller indicates they are calling for someone else and just wants general information on plans available in their area, you do not need to personalize the search if the caller does not want to. You can provide general plan information and send a personalized booklet if requested." CMS has a comprehensive quality review process on calls and we will continue to monitor calls to ensure that CSRs are pursuing the general search when appropriate.

At the same time, we believe that GAO presents this finding in a way that is incorrect and misleading. We believe that the 41% accuracy rate unfairly portrayed how accurately CMS answers questions on drug plan options without beneficiary personal identification information, when the GAO failed to analyze 35 out of the 41 responses. In actuality, when the responses are analyzed, correct answers are actually being provided a majority of the time. Further, the bulk of the responses characterized as "inaccurate" were related to the test caller's request that the CSR use only brand name drugs (i.e., no generic drug substitution). This request is highly unusual in our call experience as generic versions of a drug are identical in their clinical effects. However, we have subsequently modified the web tool used by our CSRs to make it easier to override the generic drug substitution logic in the tool.

Monitor the accuracy and completeness of CSRs responses to callers' inquiries and identify tools targeted to improve their performance in responding to questions concerning the Part D benefit, such as additional scripts and training.—We have worked hard to ensure beneficiaries have access to accurate and clear information when they call 1-800-Medicare. Our ongoing monitoring program, which evaluates a random sample of hundreds of actual calls received each month, has found that calls to 1-800-MEDICARE in 2006 have been answered accurately 93 percent of the time. The high accuracy rate is reflected in high rates of overall satisfaction from 1-800-MEDICARE callers, which averaged 84 to 85 percent in February and March.

Improve the usability of the Part D portion of the Medicare website by refining web-based tools, providing workable navigation features and links, and making web-based forms easier to use and correct.—CMS is continually enhancing and refining their web-based tools to provide Medicare beneficiaries and their caregivers the information needed to compare, choose and enroll in a prescription drug plan that best meet their needs. We summarize some of our recent enhancements below. Online enrollment has been highly successful, as evidenced by the 3 million beneficiaries who have enrolled in the prescription drug plans using CMS' web-based drug plan finder. Our partner organizations have used the web tools to assist millions more with their enrollment-related needs. The high level of online enrollment and use by partners indicates that many people have found that this resource is useful and effective for undertaking the most important step of enrolling in a drug plan, and we are pleased that thousands more are using it every day.

We cannot emphasize enough CMS' commitment to continuously improve the communications with beneficiaries and other constituents. We want our websites to continue to be recognized as benchmarks for excellence. Attachment A outlines improvements that we have made to the website since the GAO review and we believe demonstrate our continued commitment to excellence.

All of our communications methods, in conjunction with our far-reaching grassroots efforts, have helped provide the important information about Part D needed by beneficiaries, providers and partners to ensure the Medicare drug program is a success. In fact, the vast majority of beneficiaries are using their coverage to save money and get protection for the future: actual premiums and drug costs are much lower than had been expected because of strong competition, and because beneficiaries are using the enrollment tools to choose plans that save them more (over

73 percent of beneficiaries are enrolling in plans stand-alone prescription drug plans with premiums below the average); the drug plans are successfully filling over three million prescriptions a day; and each week hundreds of thousands of beneficiaries are enrolling in the new program.

Tab A attached provides additional details about our communications materials and approaches. Also attached are technical comments for your consideration in Tab B. We will use the findings of the GAO report going forward as we continue our commitment to ensure that Medicare beneficiaries have the information they need to make informed health care decisions.

Tab A

DETAILED INFORMATION ABOUT PART D EDUCATION AND OUT-REACH

Over the past two years, we have dedicated significant resources to the development and implementation of an extensive education and outreach campaign surrounding Medicare prescription drug coverage, including a variety of beneficiary publications and materials, the 1-800-MEDICARE helpline, the Medicare Prescription Drug Plan Finder web tool on www.medicare.gov, personalized assistance via the State Health Insurance Assistance Program (SHIP) counseling program, and local enrollment events. All of these initiatives are rooted in a foundation of continuous quality improvement that involves identifying the information that needs to be conveyed, using consumer research to determine the most effective messages and vehicles, preparing materials accordingly, and measuring material effectiveness. This thorough, comprehensive and careful process ensures that all of our educational materials are as accurate, clear and informative as possible.

Handbook and other written materials

CMS has produced and disseminated an unprecedented number of written communication products on Medicare prescription drug coverage. These materials meet their intended goal of quickly and easily providing action-oriented information on a variety of topics related to Part D. Written materials exist in the form of booklets, brochures, fact sheets and letters. Some key communication products are available in Braille and audiotape, and many have been translated into alternate languages to increase accessibility to information.

Medicare & You Handbook

- The Handbook is an important information source for all Medicare beneficiaries on the Medicare program and their medical and drug coverage. Each year, all beneficiary households receive a copy and we know from our consumer research that beneficiaries keep it to use as a reference source. Our customer surveys of beneficiaries who read the *Medicare & You 2006 Handbook*, conducted in January–February 2006, showed that 72 percent were “very” or “somewhat satisfied” with the *Handbook*.
- For 2006, we updated the *Medicare & You Handbook* to reflect information on the new Medicare prescription drug coverage by including a summary of the new coverage and information on how it can help Medicare beneficiaries in different situations. In addition, we reorganized the *Handbook* to help Medicare beneficiaries decide whether and how to choose among alternative plans. For example, a prominently highlighted box on the inside cover of the *Handbook* serves to remind beneficiaries that they need to make a choice about prescription drug coverage for 2006. Beneficiaries are directed to the specific *Handbook* section that provides more details on how to select a prescription drug plan.
- The *Medicare & You Handbook* has been designed to assist beneficiaries in deciding how to choose a plan based on cost, coverage, convenience and peace of mind both now and in the future. In addition to general information, the *Handbook* includes information for beneficiaries based upon their current prescription drug coverage status.
- CMS uses a series of steps before, during, and after printing the *Medicare & You Handbook* to ensure accuracy. Some steps may be combined or omitted as appropriate for other targeted publications and deadlines for publication.
- Before printing the *Handbook*, CMS conducts multiple rounds of internal review by program staff experts in components throughout CMS. CMS also subjects the *Handbook* to expert review by external organizations. CMS solicits comments from an extensive list of advocacy groups, academic partners, industry trade organizations, Congressional staff, and other interested stakeholders. CMS writers/editors do the final proofing. Finally, the CMS Office of External Affairs/Graphics reviews the *Handbook*. CMS provides a final desk-

top publishing troubleshooting check to ensure that materials include only the files (such as logos, photos, and fonts) that CMS has legal rights to use.

- During the printing process, CMS reviews printer “blueline” copies. CMS reviews first proofs from the printer to ensure the publication layout is accurate. CMS has an opportunity to correct printer errors (generally something that was altered in the transfer from electronic file to print plate) or make author’s alterations (errors previously missed) before printing begins. Specially trained CMS and/or GPO staff go on-site to the print contractor to conduct quality assurance inspections of the publication, checking for errors as the *Handbook* is being printed.
- After printing, CMS carefully monitors and investigates reports of errors in publications, including tracking related feedback from representatives at 1-800-MEDICARE. CMS corrects publications, as needed, and issues updated electronic files and/or errata sheets to accompany printed publications.
- CMS is very concerned about the readability of our publications. We have to balance the often competing goals of explaining technical information about Medicare coverage in clear and simple language while ensuring its accuracy. We go to great lengths to explain terms that beneficiaries need to understand to address readability concerns. For example, all publications include phone numbers and web sites, in case people need more information. CMS has found that this contact information is nearly universally identified and understood by beneficiaries.
- GAO noted readability test score findings as evidence that our written documents lacked clarity. CMS doesn’t routinely perform readability tests like the Fry, SMOG, FOG or Flesch-Kincaid on completed publications. Our writers may use these tests as tools during the drafting process to provide a rough estimate of the readability level and identify elements such as passive sentences, which can be readily improved. These kinds of tests rely largely on counting syllables per word, words per sentence, and sentences per paragraph to determine a “grade level” readability score which we do not find to be a useful parameter in gauging “readability” of Medicare materials because there are terms that may be unfamiliar to the Medicare population. As such, we go to great lengths to explain concepts that may be readily understood. For example, “Medicare,” “deductible,” “formulary” and “prescription” are all multi-syllabic words that would inflate scores in these types of reading tests. However, they are terms for which there are few or no simpler substitutes. People with Medicare (and in health insurance generally), commonly recognize most of these terms. Where they don’t, as with “formulary,” we use them with careful explanation in context, which also inflates the readability test scores by adding words to the sentence. Such tests would not account for this phenomenon and it is not usually accounted for by omitting certain words in the scoring process given how many terms for which we provide detailed explanations.
- These readability test scores are somewhat misleading and incomplete as a measure of the ease or difficulty of materials.
 - Plain language and literary experts like Roger Shuy and the Georgetown University Round Table on Language and Linguistics, the Social Security Administration, the Maine AHEC Health Literacy Center, the Delegates Assembly of the International Reading Association, and the U.S. Securities and Exchange Commission state that individual’s tested literacy level and their ability to read and understand materials written at the corresponding grade level rarely match.
 - Test scores don’t take into account other criteria that improve clarity of message, like navigational cues and graphic elements.
 - It’s challenging to account for multi-syllabic terms like “Medicare” or “prescription” that are widely-understood and/or for which there are no simpler alternatives.
 - When appropriate, our publications provide a glossary to help beneficiaries understand words that may be new to them. *The Medicare & You handbook* contains such a glossary, as do our other large booklets. However, glossaries would mitigate the goals of brief fact sheets and letters, and therefore, for these types of materials, every effort is made to define difficult terms in context, which can inflate standard readability test scores.
- As an additional measure of clarity, GAO states they used 60 “commonly recognized guidelines” to evaluate our publications. It is difficult to sufficiently comment on the findings without knowing these 60 criteria, beyond the hand-

ful of examples in the report. However, it is important to note that to the best of our knowledge, these guidelines were compiled from multiple sources for the purposes of this evaluation and are not commonly recognized as a set. We look forward to the opportunity to review these guidelines and their relationship to our publications in the future, to assess where improvements might be made.

- To evaluate and improve the usability of Medicare publications, CMS hires contractors to conduct research with beneficiaries, caregivers, and other people who help beneficiaries. CMS uses focus groups to help us understand what information is important to beneficiaries. We also conduct cognitive interviews to test how well beneficiaries understand the content in our draft publications. Our drafts are revised based on the feedback that we receive.
- Consumer testing for the *Handbook* dates back to 1998. Over the years, we have qualitatively tested the *Handbook* with over 1000 aged and disabled beneficiaries, caregivers, and Medicare counselors. Each year, the basic testing is conducted in two rounds to allow for iterative improvements. Lessons learned from year to year are applied to each new version of the book.
- Multiple methods are used to test the book. The most heavily relied on method is cognitive interviews where participants are given tasks “cold,” that is without prior preparation. We’ve also relied on triads and focus groups which allow participants to generate ideas on how to improve the book.
- We also conduct “diary groups” where beneficiaries are asked to make comments on the book as they read through it at home and are then brought in for focus groups. Tested content developed for particular publications is also used in other publications as appropriate. This overlap ensures consistency across CMS publications.
- Information collected from beneficiaries earlier this year indicated that 61 percent of respondents said the *Medicare & You Handbook* was “very easy” or “somewhat easy” to understand.
- CMS elicited feedback from more than 300 beneficiaries on Part D materials. *The Medicare & You handbook* language was tested by a testing contractor, BearingPoint, with over 150 beneficiaries. This testing helped us simplify our language and explain concepts more clearly.
- GAO used similar testing methods on a smaller scale to evaluate the clarity of our written materials. We are interested in reviewing the details of the 18 tasks that were used in the interviews conducted with beneficiaries and beneficiary advisors, and understanding which tasks correlated to which tested products. GAO’s report provides no details on the tasks that respondents completed successfully, and describes only three tasks that were difficult. These three indicate that the purpose and expectations of these publications may have been overlooked. The primary goal of our written communications in this phase was awareness—to make beneficiaries aware of the new coverage, aware that they needed to take some action, and aware of the resources available to help them make decisions. None of these publications were intended to independently lead a reader through such complex activities as computing projected out-of-pocket costs. Other feedback on our publications shows they are successful in meeting their intended goals.
- The National Association of Government Communicators critiqued the *Medicare & You 2005 Handbook* for the 2004 Blue Pencil Competition. The handbook received positive feedback in the judges’ ratings. The judges rated the handbook in categories such as writing, editing, purpose, design, printing, cost effectiveness, and dissemination.
 - The judges strongly agreed that the writing was clear, concise, and appropriate for its intended audience.
 - One judge wrote, “Given the complexity of this subject, the writing is extremely clear and easy to understand. Technical terms are well explained, and needed information is easy to locate.”
 - In the area of design, another judge commented that, “Choice of font, typeface, and size; leading; and margins made the book attractive, while ensuring accessibility for users (especially seniors). Use of blue headings and other design elements contributed to ease of use, as well.”
 - In the category of purpose, the judges strongly agreed that the purpose of the handbook is clear and that the handbook gets its message across with well-supported topics. As an overall final comment, a judge wrote, “This entry is very well suited to its purpose and audience.”
- CMS began preparations for the 2007 *Medicare & You Handbook* in late December 2005. To date, staff and leadership have held input meetings with key

advocates and stakeholders, tested early draft revisions with beneficiaries, established a firm project plan, and instituted additional quality assurance and proofing processes. The *Handbook* is currently on schedule for its required mailing in the fall of this year, with a comprehensive external review process ending this week and extensive consumer testing scheduled in mid-May.

1-800-MEDICARE

It is a top priority at CMS to ensure that beneficiaries have timely access to accurate information and receive satisfactory service when contacting 1-800-MEDICARE.

- Between 2004 and the beginning of the open enrollment period, CMS conducted numerous activities to prepare for the prescription drug benefit, including the development of a comprehensive training curriculum on the prescription drug benefit and the Plan Finder tool for Customer Service Representatives (CSRs). Since November 15, 2005, CMS has made continuous updates to scripts and reference materials for CSRs to ensure they are able to communicate accurate information to beneficiaries and people calling on behalf of beneficiaries.
- CMS's quality monitoring program has found that in 2006, calls to 1-800-MEDICARE have been accurate 93 percent of the time. This quality monitoring program is conducted by contractors who run the call centers. CMS monitors at least 4 calls per month for each of our thousands of CSRs to identify improvement and training opportunities.
- These are not just mystery shopping calls, which are limited to topics chosen by researchers, but actual calls which are representative of the information Medicare beneficiaries want to know. To ensure reliability and accuracy, all monitors score a sample of calls on a weekly basis and meet to review their approaches. The data is analyzed constantly and is used to take immediate corrective action. This work is overseen by a team within CMS dedicated to the quality of the 1-800-MEDICARE call centers.
- Examples of topics receiving the highest volume of inquiries at our call centers include:
 - How to enroll in a plan to obtain prescription drug coverage
 - Complaints about drug coverage
 - How to apply for the limited-income subsidy
- Since the beginning of the new prescription drug benefit, CMS has taken many steps to help beneficiaries get the information they need to select a drug plan. For example, CMS acquired additional infrastructure including telephone lines and workstations at call center sites.
- CMS increased the number of customer service representatives (CSRs) from 3,000 in June 2004 to as many as 7,800 to handle beneficiary calls with minimal wait times.
- On average, from November 15, 2005 to April 12, 2006, callers have experienced wait times of less than 2 minutes, with longer waits sometimes occurring during peak call periods. Call volume to 1-800-MEDICARE peaked around 400,000 calls per day in mid-November when enrollment began, and again in early to mid-January. Currently, call volume reaches 200,000 calls per day on the highest volume day and levels out around 150,000 per day during the remainder of the week. Call volumes have continued to increase slightly since then.
- CMS recognizes that not all beneficiaries are able to use, or have access to, the internet, which is the platform for the useful Medicare Prescription Drug Plan Finder tool. As part of our outreach and communication efforts, CMS trained additional staff exclusively on the use of the Medicare Prescription Drug Plan Finder tool so that they could be dedicated to answering calls only about the prescription drug benefit and available plan options.
- We expanded responsibilities and provided additional training for some CSRs and advanced training for others. We required CSRs to take written exams and test calls for certification before allowing them to take live calls. All CSRs have one week of classroom training followed by two or three additional days of practice calls, simulation, quality monitoring, and follow-up coaching to ensure peak performance. Finally, we monitored newly-trained CSRs and those who would benefit from additional coaching at a higher level.
- This year, CMS implemented a 1-800 MEDICARE caller satisfaction survey conducted by Pacific Consulting Group, an independent contractor. This survey provides 1) satisfaction tracking over time and 2) an early warning sys-

tem that can point to potential service problems. Improvements can then be implemented relatively quickly to enhance caller satisfaction. These CMS customer satisfaction surveys indicate that the bulk of callers who interact with our CSRs, 87 percent are satisfied with their experience. They are particularly pleased with how courteous and patient the CSRs are (rated at 97 percent). These responses came not only from people with Medicare, but also friends or relatives calling on their behalf, who made up 34 percent of callers during March 2006.

- Currently, 500 surveys are conducted each week with 400 callers who spoke with CSRs and 100 callers who used the Interactive Voice Response System.

The data below depict results from weekly calls for those callers that spoke to a CSR. The results show the percentage of respondents in the weeks January 16th, February 27th and March 6th that strongly or somewhat agree with the statements listed below.

<i>Survey Metric</i>	<i>Week of</i>	<i>January 16th</i>	<i>February 27th</i>	<i>March 6th</i>
<i>(% agree—strongly or somewhat to the following statements)</i>				
CSR was helpful		84%	89%	88%
CSR understood issue or concern		83%	86%	88%
CSR explained things to me in way I could understand		83%	86%	84%
I received all the information I needed		67%	72%	73%
The CSR was knowledgeable		81%	86%	85%
I received information specific to my issue		75%	80%	80%
Overall I am satisfied		79%	84%	85%

- Pharmacists are a key partner in the implementation of the Medicare prescription drug benefit. To ensure that pharmacists have access to the information they need to assist beneficiaries at the pharmacy counter, CMS developed a dedicated pharmacist 1-866 telephone line. Incoming calls through the dedicated pharmacist line are routed to the head of the queue at the 1-800-MEDICARE number, wait times are substantially lower than the overall average for beneficiaries and other individuals calling the 1-800-MEDICARE line. This helps to relieve any burden on pharmacists, and also ensures that pharmacists are able to assist beneficiaries immediately at the pharmacy counter.
- CMS is well-prepared to handle increased call-volume that may occur before the May 15th enrollment deadline. We have increased the number of CSRs from 3,000 in June of 2004 to 6,000 CSRs for May enrollments. We have also acquired additional infrastructure including telephone lines and workstations at call center sites. We have refined our CSR scripts by reducing redundant information, indexing scripts for quick access, and including probing questions to help the CSRs better identify callers' concerns.
- Despite our efforts, some beneficiaries will wait until the deadline is near, but our top priority is to encourage people to enroll now and avoid the rush.

Medicare.gov

- To ensure that the new Plan Finder tool was well-designed and easily used by beneficiaries and other individuals, CMS worked with a professional website development contractor, CGI Federal and a subcontractor, Navigation Arts.
- As the Medicare Prescription Drug Plan Finder was being designed, CMS engaged in multiple rounds of consumer testing to ensure its usefulness and simplicity. CMS conducted three rounds of in-depth interviews with Medicare beneficiaries to obtain feedback as drafts of the tool were developed throughout 2005. Final interviews that focused on messages tailored specifically for beneficiaries based on their insurance information were conducted in September 2005. CMS conducts ongoing consumer research to continue to improve understandability and usability.
- CMS also conducts thorough and ongoing analyses of possible outliers in data, including the Medicare Prescription Drug Plan Finder plan pricing data, pharmacy network, mismatched formulary identifiers (NDC codes), and other missing formulary data. If problems are found with a plan's data, information on the plan will be suppressed from the website until CMS works with the plan to correct its information and properly display it.

- We are proud to say that CMS has received a number of awards for its website from independent organizations. These awards include the “eHealthcare Leadership Award” at the Ninth Annual Internet Conference, the “2005 Pioneer Award” at the E-Gov Institute and Federal Computer Week, and the “Independent Technology Supporting Service to Our Country” award at the Eighth Annual Technology Gala to benefit Juvenile Diabetes.
- We believe that the website has been extremely successful in providing beneficiaries, their caregivers and CMS partners with clear, accurate and timely information to help them enroll in drug plans. In fact, CSRs at 1-800-MEDICARE have access to the Plan Finder to help beneficiaries find the information they need about choosing a plan, enrolling in a plan, or other issues related to accessing their prescription drug coverage. The Plan Finder also has been a critical tool for SHIPs and other partners, such as the ABC Coalition and Medicare Today, to use when conducting outreach to beneficiaries.
- Results from a web-based customer satisfaction survey conducted by MSInteractive, a subsidiary of Market Strategies that specializes in web-site satisfaction research, were very positive. This research, conducted in December 2005, focused only on the prescription drug plan finder tool.
- The survey indicated that content, interactivity, and navigability have the greatest impact on satisfaction. During development of the tool, CMS contracted with a web design firm to leverage their expertise on these impacts. CMS continues to focus on these areas in future enhancements and updates.
- The site’s “appearance” and “privacy” scored highly, but had no impact on overall satisfaction.
 - 66 percent of those who enrolled were either “somewhat” or “strongly satisfied” with the tool.
 - 80 percent of those who enrolled would recommend the tool to a friend.
 - 70 percent of users agreed with this statement, “I know more about the Medicare Prescription Drug Plans now that I’ve used this site.”
 - Regular internet users had higher ratings of the site.
 - In January and February 2006, Abt conducted a telephone survey of a random sample of beneficiaries and found that:
 - 14 percent of respondents used the www.medicare.gov website to get information about Medicare;
 - 60 percent said it was “very easy” or “somewhat easy” to understand the information from www.medicare.gov;
 - Beneficiaries who rated their satisfaction with the information received from www.medicare.gov as “very/somewhat” satisfied outnumbered the “dissatisfied” beneficiaries 71 percent to 19 percent. Seven percent of beneficiaries were neither “satisfied nor dissatisfied.”
- Overall, the drug plan finder element of the website has received 164.6 million page views between November 15, 2005 and April 26, 2006. We do not have a way to differentiate whether those hits were from beneficiaries or their caregivers.
- To date, 3 million beneficiaries have enrolled in prescription drug plans using the Plan Finder. That indicates that at least that many people were satisfied enough with the information they received to undertake the most important step of enrolling in a drug plan.
- The Frequently Asked Questions (FAQ) section of www.medicare.gov has been accessed more than one million times since January 1, 2006. CMS has also responded to more than 19,000 emails received through the FAQ section, with 93% of them being resolved satisfactorily in the first response.

State Health Insurance Assistance Programs (SHIPs)

- While the SHIPs play a significant role in beneficiary counseling and education on Part D, CMS has also created a national grassroots network of more than 24,000 partners and 140 coalitions that rely on traditional tools to help them provide personalized counseling to Medicare beneficiaries every day.
- The network CMS built is diverse and committed, with members from every sector, including advocacy groups, government agencies, service clubs, faith-based organizations, benefits counselors, trained volunteers and healthcare professionals such as doctors and pharmacists.
- This extensive, grassroots-level partnership is truly unprecedented for the Medicare program. It’s reaching out to people with Medicare all over the country . . . “where they live, work, play, and pray.” This approach has helped personalize Medicare in every corner of the country.

- Preliminary data from the State Health Insurance Assistance Programs (SHIPs) shows that individual in-person and telephone contacts, presentations and meetings reached a total of 4.5 million clients, compared to 2.5 million in the previous grant period.

Other Selected Activities

- The Mobile Office Tour has traveled 500,000 miles since last fall and approximately half of the territory covered and events have been in rural areas, in an attempt to reach out to a variety of beneficiaries and partners at the local level. We knew we would have to develop a grassroots capacity and local networks to supplement the CMS regional structure to provide the necessary education and enrollment assistance at the community level. This would involve reaching out, not just to our traditional partners such as the SHIPs, but to all the groups and organizations that have contact with our beneficiaries on a daily basis “where they work, where they play, and where they pray.” We needed to involve individuals and institutions: family members and friends; current and former employers; churches and synagogues; financial advisors and community centers, to name but a few.
- CMS is reaching out directly to beneficiaries through an extensive paid and earned media campaign focusing on press and radio, both of which are highly localized in informing beneficiaries of special events in their neighborhoods.
- As we approach May 15, many members of the Cabinet whose agencies have helped build awareness of the prescription drug benefit through their own programs have joined efforts with CMS, including the United States Department of Agriculture, Department of Commerce, Department of Labor and Housing and Urban Development.
- To minimize a possible last minute rush to enroll, CMS is making a monumental effort to enroll beneficiaries well before the May 15th deadline. In the past month, there have been 1,000 events per week across the country to provide beneficiaries with personalized help so they understand the prescription drug coverage options available to them and they can enroll in a plan. In our enrollment efforts, we are targeting beneficiaries who may qualify for the low-income subsidy and beneficiaries who live in rural areas. Our enrollment events are fully coordinated with the Social Security Administration (SSA) to assist beneficiaries in applying for extra help, as well as to help them enroll in a plan.

Tab B

TECHNICAL COMMENTS FOR FURTHER CONSIDERATION

- Regarding GAO finding for www.medicare.gov tool that defaulting to generic drugs complicates a user’s search for drug plans covering brand name drugs:

CMS made a deliberate decision to default to generic substitution of brand name drugs. A user is able to override the default. However, because of the great opportunity for beneficiary savings and the absence of any medical difference between brand and generic versions of a drug, we want to emphasize that generic drugs are the same as the brand name drug in active ingredients, dosage, safety, strength, how it is taken, how it works in the body, quality, performance, and intended use. Therefore, the Agency stands behind its decision to default to direct generic substitution. We have provided below the exact language from the Medicare Prescription Drug Plan Finder website. In addition, in response to a GAO suggestion, we have changed the site so that if a user opts to override the generic substitution, that change is persisted even when the user makes other changes such as the addition of drugs.

The language from the site is: We recommend that you let us price plans in your area using the lower-cost generic version of your selected drug(s). A generic drug is safe and effective and it has the same risks and benefits as the original brand-name drug but at a lower cost.

Today, MOST prescriptions are filled with generic drugs. A generic drug is the same as a brand-name drug in active ingredients, dosage, safety, strength, how it is taken, how it works in the body, quality, performance, and intended use. Generic drugs are less expensive because generic drug companies compete to provide drugs after the drug patents end. Generic drugs are thoroughly tested and must be approved by the Food and Drug Administration.

If you choose not to use the lower-cost generic drugs, we will price the drugs as you entered them. You should be aware that some plans do not

cover the brand version of a drug if the generic is available. If you purchase a drug that is not covered by the plan, you will pay the full price of the drug, and the amount you pay will not be counted towards your deductible or out of pocket cost limits.

- Regarding 1-800-MEDICARE Average Speed of Answer:

CMS is staffing 1-800-MEDICARE at a level to achieve an average speed of answer of 3 minutes or less as measured over a month time period. We have consistently achieved this goal even in the month of January where we handled 5.8 million calls. During the month, there will be periods of time where the call wait time is under or over the 3 minute level with longer waits occurring during spikes. We use an “all hands on deck” where supervisors, trainers, etc. take calls to help manage the spike periods and we change staffing patterns as needed where changes in call patterns are noted. In particular, over this time period, we have increased staffing at the late night hours and weekends as a result of increased calls in the 11 pm–1 am timeframe. The actual average speed of answer for recent months is listed below.

Month	Average Speed of Answer for Month
January	2.49 mins
February	0.51 mins
March	0.25 mins
April	0.50 mins (actual for 4/1–15)

- Regarding 1-800 MEDICARE CSRs’ inability to respond with caller’s personal information:

1-800 MEDICARE CSRs do have the ability to use the non-authenticated, general search for callers who do not have their Medicare number. However, CMS has encouraged CSRs to stress the importance of authenticated Prescription Drug Plan Finder searches to callers. The importance of authenticated searches is stressed in the CSR training materials and scripts. We have placed warnings throughout the training materials about the downside of proceeding without the personalized information and CSRs do suggest that the person call back when they have it.

While we realize the importance of authentication, we have emphasized to CSRs through refresher training and broadcast messages that there will be occasions in which callers will be inquiring on behalf of a beneficiary. It has been emphasized to CSRs that non-authenticated general information is to be shared if the caller is unable to provide specific information that would enable a more detailed search. The additional reminders released state the following: If a caller indicates they are calling for someone else and just wants general information on plans available in their area, you do not need to personalize the search if the caller does not want to. You can provide general plan information and send a personalized booklet if requested.

- Regarding Compliance with Section 508

CMS submitted a copy of the Voluntary Product Assessment Template (VPAT) on February 27, 2006, as well as Watchfire WebXM reports on March 13 & April 24, 2006. The 508 findings in these reports were minor and based on mostly false positive results. One issue dealt with occasional missing ALT text on images and another issue dealt with form labels.

A number of applications on Medicare.gov, including MPDPF, include a tabbed interface. In MPDPF, there are 3 tabs: Prescription Drug Plan Finder, Learn How Plans Work, and Plans in Your State.

To enable some Javascript code within the tabs, the links are coded as a simple form (with no input fields).

The Watchfire WebXM suite expects to see a traditional form with input fields, which should always have associated labels for maximum accessi-

bility. However, since there are no input fields, label tags would be inappropriate in this context.

These reports confirm that the site complies with the Rehabilitation Act Amendments of 1998 (Section 508).

- Regarding GAO recommendation that CMS improve usability of the Part D portion of website:

The Medicare Prescription Drug Plan Finder has monthly releases and ad hoc enhancements to provide Medicare beneficiaries and their caregivers the information needed to compare, choose, and enroll in a prescription drug plan that is right for them.

The following are a few of examples of recent site improvements:

- **Drug information savings functionality:** This functionality allows users to save their drug information during their initial session and retrieve it easily each time they revisit the Web site with just a confirmation number and a password date. This allows them to compare plans directly without taking the time to reenter all their medications.
- **Print My Drug List functionality:** This functionality allows beneficiaries/users to print out and conveniently keep a record of their medication list that they can use when needed, such as during doctor's appointments or visits to the ER.
- **Drug Details page:** This page provides a complete overview of a plan's benefit, specific to the drugs the beneficiary/user has entered. It provides the full cost of the drug, cost of the drug during every phase of the benefit (i.e. during the deductible, initial coverage, gap, and catastrophic phase) and coverage restriction information (i.e. step therapy, quantity limitations, and prior authorization). In a simple table format, beneficiaries/users can view and understand what their drug cost will be throughout the year and what if any restrictions exist for coverage of their drugs.
- **Improvements on the drug entry functionality:** A number of improvements have been made to the drug entry functionality with the goal of allowing beneficiaries/users to easily find their medication and enter their specific dose and quantity.

Appendix IV: Agency Comments and Our Evaluation

We received written comments on a draft of our report from CMS (see app. III). CMS said that it did not believe our findings presented a complete and accurate picture of its Part D communications activities. CMS discussed several concerns regarding our findings on its written documents and the 1-800-MEDICARE help line. However, CMS did not disagree with our findings regarding the Medicare Web site or the role of SHIPs. CMS also said that it supports the goals of our recommendations and is already taking steps to implement them, such as continually enhancing and refining its Web-based tools.

CMS discussed concerns regarding the completeness and accuracy of our findings in terms of activities we did not examine, as well as those we did. CMS stated that our findings were not complete because our report did not examine all of the agency's efforts to educate Medicare beneficiaries and specifically mentioned that we did not examine the broad array of communication tools it has made available, including the development of its network of grassroots partners throughout the country. We recognize that CMS has taken advantage of many vehicles to communicate with beneficiaries and their advisers. However, we focused our work on the four specific mechanisms that we believed would have the greatest impact on beneficiaries—written materials, the 1-800-MEDICARE help line, the Medicare Web site, and the SHIPs. In addition, CMS stated that our report is based on information from January and February 2006, and that it has undertaken a number of activities since then to address the problems we identified. Although we appreciate CMS's efforts to improve its Part D communications to beneficiaries on an ongoing basis, we believe it is unlikely that the problems we identified in our report could have been corrected yet given their nature and scope.

CMS raised two concerns with our examination of a sample of written materials. First, it criticized our use of readability tests to assess the clarity of the six sample documents we reviewed. For example, CMS said that common multisyllabic words would inappropriately inflate the reading level. However, we found that reading lev-

els remained high after adjusting for 26 multisyllabic words a Medicare beneficiary would encounter, such as Social Security Administration. CMS also pointed out that some experts find such assessments to be misleading. Because we recognize that there is some controversy surrounding the use of reading levels, we included two additional assessments to supplement this readability analysis—the assessment of design and organization of the sample documents based on 60 commonly recognized communications guidelines and an examination of the usability of six sample documents, involving 11 beneficiaries and 5 advisers.

Second, CMS expressed concern about our examination of the usability of the six sample documents. The participating beneficiaries and advisers were called on to perform 18 specified tasks, after reading the selected materials, including a section of the *Medicare & You* handbook. CMS suggested that the task asking beneficiaries and advisers to calculate their out-of-pocket drug costs was inappropriate because there are many other tools that can be used to more effectively compare costs. We do not disagree with CMS that there are a number of ways beneficiaries may complete this calculation; however, we nonetheless believe that it is important that beneficiaries be able to complete this task on the basis of reading *Medicare & You*, which, as CMS points out, is widely disseminated to beneficiaries, reaching all beneficiary households each year. In addition, CMS noted that it was not able to examine our detailed methodology regarding the clarity of written materials—including assessments performed by one of our contractors concerning readability and document design and organization. We plan to share this information with CMS.

Finally, CMS took issue with one aspect of our evaluation of the 1-800-MEDICARE help line. Specifically, CMS said the 41 percent accuracy rate associated with one of the five questions we asked was misleading, because, according to CMS, we failed to analyze 35 of the 100 responses. However, we disagree. This question addressed which drug plan would cost the least for a beneficiary with certain specified prescription drug needs. We analyzed these 35 responses to this question and found the responses to be inappropriate. The CSRs would not provide us with the information we were seeking because we did not supply personal identifying information, such as the beneficiary's Medicare number or date of birth. We considered such responses inappropriate because the CSRs could have answered this question without personal identifying information by using CMS's Web-based prescription drug plan finder tool. Although CMS said that it has emphasized to CSRs, through training and broadcast messages, that it is permissible to provide the information we requested without requiring information that would personally identify a beneficiary, in these 35 instances, the CSR simply told us that our question could not be answered. CMS also said that the bulk of these inappropriate responses were related to our request that the CSR use only brand-name drugs. This is incorrect—none of these 35 responses were considered incorrect or inappropriate because of a request that the CSR use only brand-name drugs—as that was not part of our question.

Chairman JOHNSON OF CONNECTICUT. Thank you.
Ms. Larkin.

STATEMENT OF JOYCE LARKIN, VICE PRESIDENT, PUBLIC AFFAIRS AND COMMUNITY RELATIONS, OVATIONS, UNITED HEALTH GROUP

Ms. LARKIN. Thank you, Chairwoman Johnson and Representative Stark and the other Members of this Subcommittee. I appreciate the opportunity to testify before you today about the implementation of the new Medicare Part D drug benefit. My name is Joyce Larkin, and I am vice president of public affairs and community relations for Oventions, a United Health Group company.

Oventions is solely dedicated to meeting the health care needs of individuals age 50 and over, including those who are Medicare eligible, those with lifelong chronic conditions, and those who are disabled. I should say that prior to joining Oventions, I spent 15 years working here on the Hill for one of your distinguished colleagues, Congressman Stokes of Ohio, a real health care champion, so it is a real pleasure to be here today.

Our company has a life-long commitment to enhancing health care for older Americans. We do that by our participation in Medicare fee-for-service programs, health plans, and demonstration programs for frail Medicare beneficiaries. As you know, Ovation is the only company to offer the Medicare Part D benefit in all 50 States, the District of Columbia, and each of the U.S. territories that has Part D programs.

Since January, we have processed approximately 50 million prescription drug claims. Our savings projections align with what CMS has projected, roughly \$1,100 per year for beneficiaries who previously lacked coverage. As CMS also reported, we are the leading sponsors for both the Medicare prescription drug plans or PDPs and also the Medicare Advantage plans, which now have prescription drug coverage. We believe that our experience provides an opportunity to offer insight to this panel as you continue to evaluate the Medicare drug benefit.

Before the startup of the program, we engaged in a broad national education campaign around Part D. Our goal was to ensure that individuals understood the benefit and how to enroll prior to the enrollment season. As part of this effort, we developed a consumer booklet, which became known as the Show Me Guide. We published the booklet at no cost to consumers in seven languages and distributed more than 10 million copies.

Today, we appreciate the opportunity that we have had to work with some very strong advocacy groups and Congressional groups around education. Our partnerships have included working with the Congressional Black Caucus; Reverend Jackson and the Rainbow-PUSH Coalition; the National Kidney Foundations; the National Medical Association; and the American Association for Services and Homes for the Aging. These partnerships have resulted in more than 400 Medicare Part D education and outreach events around the country. In some States, such as Illinois, we have participated in more than 50 such events.

We continue to be encouraged by the stories we are hearing every day about people receiving prescription drug coverage for the first time: beneficiaries such as Fran Cooper, a person who was very skeptical about the program in the beginning. She is now saving money, and she is going around the country educating other beneficiaries. Betty Noord, a Medicare beneficiary in Wisconsin, her choice was a Medicare Advantage plan, which now offers her a zero premium along with prescription drug coverage. She is estimating that her costs have decreased from \$9,000 to roughly \$2,000 per year.

It is clear that implementing a program of this scale is an enormous task, and it does not come without challenges. For United, more than 4.5 million enrollees are participating in Part D through our program; nearly 3 million of which are enrolled in our stand-alone Part D plans.

While these numbers are impressive, we share your concern that the system has not worked well for some beneficiaries. This includes some low-income individuals as well as some that are dual eligible. I can commit to you that we will continue to do all that we can to ensure that those problems and those issues are addressed.

We have done things to help beneficiaries, such as increasing our call center staff, decreasing the time that consumers have had to wait for information, deeming individuals eligible for coverage so they did not have to leave the pharmacy without their prescriptions, and working with pharmacies, independent pharmacies, retail pharmacy outlets, to make sure that the Part D experience is positive for them. While some of our implementation challenges are behind us, we want to make sure that this benefit works well for every single consumer.

So, I appreciate the opportunity to appear before this panel today and would welcome any questions that you might have.

[The prepared statement of Ms. Larkin follows:]

**Prepared Statement of Joyce Larkin, Vice President, Public Affairs and
Community Relations, Ovations, UnitedHealth Group**

Introduction

Ovations, a business unit of UnitedHealth Group, is pleased to submit this testimony to the Subcommittee on Health for its consideration. Ovations is solely dedicated to meeting the healthcare needs of individuals age 50 and over, including those who are Medicare eligible, people with lifelong chronic conditions, the frail elderly and people who are disabled.

Our company has a long-standing commitment to enhancing health care for older Americans and other Medicare beneficiaries. In fact, we provide the most comprehensive array of health and well-being services to these populations through the traditional Medicare fee-for-service program, health plans, and demonstration projects for the frailest Medicare beneficiaries. Our participation in Medicare programs is fundamental to our core mission: to facilitate broad and direct access to affordable, high quality health care that results in improved health outcomes for individuals, families and communities.

As you know, Ovations/UnitedHealth Group is the only company to currently offer the new Medicare prescription drug benefit in all 50 States, the District of Columbia and each of the U.S. territories covered under the Part D program. A little over four months ago, Medicare beneficiaries who were enrolled began using the new Medicare prescription drug benefit.

Since January 1 we have processed approximately 50 million prescription drug claims, with beneficiaries yielding savings consistent with the Centers for Medicare & Medicaid Services' (CMS) estimate of \$1,100 per year for beneficiaries who previously lacked prescription drug coverage. As CMS recently reported we are the leading sponsor in terms of enrollment for both stand-alone Medicare Prescription Drug Plans (PDPs) and Medicare Advantage Plans with Medicare Prescription Drug Coverage (MA-PDs).

With our experience in working with CMS and Congress to implement the new Medicare drug benefit, we believe we can continue to offer a valuable perspective as this Committee exercises its oversight in evaluating the new Medicare prescription drug program.

Early Challenges

Implementing a program of such unprecedented size and scale is an enormous task and has not been without challenge. CMS has reported the Medicare Part D program is now contributing to the well-being of more than 30 million beneficiaries as of April 18, including more than eight million Medicare beneficiaries enrolled in PDPs who have signed up individually for prescription drug coverage. As of March, more than 4.5 million enrollees were participating in Part D through our PDP and MA-PD plans. CMS reported as of the end of April that nearly 3.8 million beneficiaries were enrolled in our stand-alone Part D plans. Approximately one-third of these beneficiaries are dual eligibles.

While these numbers and statistics demonstrate the Medicare Part D program is working for millions of Medicare beneficiaries, we share the Committee's concern that, in some cases, the system has not worked well for all beneficiaries. This was especially true for low-income and dually eligible enrollees, largely due to unanticipated information gaps in the system. At the outset of the program, information on eligibility was not available to pharmacies for certain duals and other low-income beneficiaries in the way it should have been, primarily due to:

- Incomplete enrollment and eligibility information received by the health plans and delays in its transfer among CMS, health plans and pharmacies; and
- Late-month enrollments and switches from one plan to another by duals and other low-income beneficiaries leading to delays in posting eligibility information in the system.

The resulting challenges in determining eligibility led to people not being found in the system or their temporary classification in a standard low-income coverage tier, making their initial co-payments higher than expected. It also resulted in an unanticipated surge in call volumes, creating delays in response to both consumers and pharmacists.

Responding to the Challenges

We have done, and are continuing to do everything we can to work with CMS, the Social Security Administration, states, pharmacists, and other partners to help resolve outstanding enrollment and information technology system issues.

Early on, when we recognized there was an issue with certain beneficiaries such as duals and other low-income individuals accessing their benefits, we acted quickly to ensure that these individuals would have immediate access to their Part D benefit regardless of whether they appeared immediately in the system, including:

- Activating a beneficiary's plan coverage by "assuming" or "deeming" an individual's enrollment even before receiving confirmation of enrollment from CMS, where possible;
- Assigning beneficiaries to a subsidized co-payment class even in advance of a CMS confirmation;
- Lifting on a temporary basis prior authorization and step edit requirements on almost all medications in order to give pharmacists and enrollees ample time to adjust to their new Part D plans. We retained prior authorization on a very small number of drugs for which our Pharmacy & Therapeutics Committee has special safety concerns for older adults; and
- Dramatically increasing call center staff available to assist beneficiaries and pharmacists by resolving issues related to the program's early data problems. As a result of these efforts, we are pleased to report for the month of March that we received over 1.3 million calls from beneficiaries, while achieving an average speed to answer of approximately 15 seconds and a less than 1.5% abandonment rate. Our call lines dedicated to supporting pharmacists achieved similar levels of performance.

While many of these early implementation problems seem to be behind us, we are mindful of the challenges ahead in ensuring that the Part D implementation proceeds smoothly. That is why we continue to be focused on working more closely with pharmacists, including community pharmacists, on our own and through our trade association. We appreciate the important role that pharmacists are playing in the implementation of the new Medicare drug benefit. Our work with them has included, among other actions, making rapid improvements in call center operations, enhancing pharmacist support, and developing temporary solutions to meet the needs of low-income beneficiaries while longer-term problems are being resolved.

We also have understood the need to proceed gradually as we move beyond issues related to Part D's initial implementation. As an example of this understanding, we have taken a very gradual, phased approach to the end of the extended 90-day transition period. Our approach is to phase in utilization management programs over a period of months, beginning with requirements important to determining whether a drug should be billed under Medicare Part B or D. It also involves eliminating a number of requirements entirely and "grandfathering" beneficiaries for many medications. By grandfathering we are able to permit individuals who accessed certain drugs during the extended transition period to remain on these drugs without having to initiate an administrative request known under Part D as a coverage determination.

Our approach to preparing for challenges also extends to our planning for the May 15 enrollment deadline. We are pleased to report that we continue to receive an extremely high volume of enrollment applications, by mail, telephonically, and over the internet. We expect these volumes to increase as the May 15th enrollment deadline approaches. In order to meet this continued strong demand for our program and ensure high levels of service, we are taking steps to ensure that our call centers are appropriately staffed and ready.

- We now have more than 3,600 call center representatives deployed at multiple call centers. This represents a 50% increase in our staffing levels from November. For May 15, we are also increasing our call center staff rotations,

expanding our call center hours so that representatives are available to assist with enrollment questions 24/7, and are using our experience from January to learn how to better “load balance” calls between our various call centers. As a result of these actions, we feel very confident going into May 15 that Medicare beneficiaries will find enrolling in one of our plans an easy and pleasant experience.

Finally, we appreciate the continuing need to work closely with states as Part D’s implementation continues. In this regard, we appreciate the steps that were taken by states in the early months of the program to help address gaps in coverage for low-income beneficiaries. We also appreciate the vitally important work that State Health Insurance Assistance Programs (SHIPs) continue to undertake in assisting Medicare beneficiaries in understanding the Part D program and their enrollment options. The importance of states to the Part D implementation and SHIP offices in particular was driven home to us a few weeks ago when, as many of you know, we mailed out late payment notices, based on a CMS model, to a number of our enrollees. While our intention in sending the notices was to encourage members to contact us with any issues or concerns about their Part D payment status or selected payment method, this intention was not well communicated and generated many calls from beneficiaries. While we ultimately spoke with more than half of the beneficiaries who received a notice, it was the SHIPs that served as the first line of defense in receiving these calls, and, as we have communicated directly to all SHIP offices, we appreciate greatly the efforts they undertook to assist our members.

Our Commitment

Most important as we look ahead to Part D’s continuing implementation is our commitment not just to the program, but to the people we serve. We have reached out to Medicare beneficiaries in communities across the nation to help them understand the new Medicare drug benefit and our campaign to do so is ongoing.

Well before January, we engaged in a broad national educational campaign about Part D. The goal was to ensure that individuals eligible for the Part D benefit would understand their options and know how to access and make full use of the new prescription drug benefits available to them under Medicare.

As part of this effort, we developed an educational consumer booklet known as the *Show-Me Guide*. We published the *Show-Me Guide* in seven different languages (English, Spanish, Chinese, Russian, Vietnamese, Korean, and Tagalog) and distributed more than 10 million copies of the *Guide* to consumers, providers, advocates, and governmental representatives at both the state and federal levels.

We are honored and appreciate the opportunity to work in partnership with national and community-based organizations on this important initiative. Our partnerships have included, but are not limited to, Representative Donna Christensen and the members of the Congressional Black Caucus; Reverend Jesse Jackson and the Rainbow/PUSH Coalition; the National Kidney Foundation; the National Medical Association; and the American Association of Services and Homes for the Aging. These partnerships have resulted in more than 400 Medicare Part D education and outreach events being held. In some states such as Illinois, we have participated in more than 50 Medicare Part D education events. Many of the organizations with which we have partnerships have asked if we would be willing to continue to work with them to make certain that Medicare beneficiaries are receiving information on an ongoing basis.

We continue to be encouraged by the stories we hear every day about people receiving prescription drug coverage for the first time and about seniors who are keeping more money in their pockets through the cost savings realized under their new Medicare Part D Plan. We have worked with thousands of people across the country on a one-on-one basis, educating them about the benefits of the Part D prescription drug program.

People like Fran Cooper, a Medicare beneficiary in Nebraska who enrolled in the AARP MedicareRx Plan. Fran, who was initially skeptical, now saves money each month on her prescription drugs. Fran has become a Medicare Part D “champion.” She is participating in events with the Congressional Black Caucus, the National Medical Association and other groups to educate African-Americans and communities of color about the new Medicare drug benefit.

Betty Nord is a Medicare beneficiary in Wisconsin who was attracted to our Medicare Complete product, one of our Medicare Advantage Plans. She liked the product because it offered the new Medicare prescription drug coverage with a zero premium. Betty is now enrolled in Medicare Complete and estimates that her medical costs have been reduced dramatically from approximately \$9,000 to \$2,000 per year.

And then there is Barbara Stetson, an 81-year old Medicare beneficiary who lives in Maine. Ms. Stetson took the time to send a special “thank you” letter, because having the Medicare drug benefit is making a substantial difference to her. Before enrolling in the AARP MedicareRx Plan, Barbara was not taking her medications appropriately, simply because she could not afford to buy them. She now has peace of mind and the prescription medications that she needs each day.

In addition to providing beneficiaries immediate savings, Part D coverage is providing seniors and others eligible for Medicare with a safety net in case they ever would need it. The knowledge that they will be protected if their situations change and their drugs costs rise offers Part D beneficiaries some peace of mind—a truly valuable benefit for both individuals and their families.

We believe that the Medicare Part D benefit is helping to make affordable prescription drug coverage available to millions of seniors and disabled individuals, including those who previously would not have qualified for assistance through other federal or state programs.

Consistent with our commitment to our enrollees is our philosophy regarding plan design. Ovations strove to ensure that our formulary was one of the broadest, most open and non-restrictive. Ovations’ formulary as we developed it covers 100% of CMS’ top 100 volume drugs without requiring prior authorization. It also is one of the few formularies to include all 178 Part D covered drugs that the Health and Human Services’ Inspector General reports as most commonly used by dual eligibles. And, the Ovations formulary originally contained just 39 drugs with prior authorization requirements and five with step therapy requirements. Again, as indicated, we temporarily suspended these requirements for all but a few drugs in order to give pharmacists and enrollees ample time to adjust to their new Part D plans. As mentioned, some of these requirements have now been removed entirely, and others are being gradually phased back into place.

Still More to Do

Despite the start-up issues, there is much good news to talk about with respect to the Part D program. However, our work to make the program succeed for all beneficiaries, and very importantly to ensure that those who need it most are signing up, is by no means finished. We are resolute in our commitment to help deliver on this promise for *all* beneficiaries.

Critical in this regard is the particular importance of helping lower-income individuals, especially those not eligible for Medicaid, understand the value of enrolling in Part D. There are an estimated six to eight million low-income people who should qualify for subsidies under Part D but are not eligible for Medicaid. These are people who likely have no prescription drug coverage and stand to benefit most from a reliable source of coverage that makes prescription drugs available to them on an affordable basis. To accomplish this objective, it is important that we join together to reach out to these beneficiaries, clarify any misperceptions about the program, and remove whatever barriers exist to their enrolling in Part D.

Conclusion

In conclusion, we would like to say that we believe the Medicare prescription drug program is working well for the vast majority of beneficiaries. Enrollees in UnitedHealth Group/Ovation’s Medicare Part D plans are realizing significant savings and report a high degree of satisfaction. And the program overall, as CMS has reported, is delivering access to medications for millions of beneficiaries while yielding significant savings.

Ovations/UnitedHealth Group is committed to working with you, CMS, the Social Security Administration, states, pharmacists, and beneficiaries to address current and future challenges. We are determined to do all we can to fulfill the promise of this ambitious and valuable program. We hope that we can be a constructive force to that end and look forward to working with you in the months to come. We especially appreciate the Committee’s leadership on this important matter and thank you for the opportunity to share our thoughts.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Ms. Larkin.

Mr. Steinberg.

Mr. STARK. Madam Chair, if you could yield, I just had promised Mr. Ramstad that I would welcome Ms. Larkin on his behalf. Her company is a constituent of Mr. Ramstad’s, and Ms. Larkin

flew quickly overnight to be here. Mr. Ramstad was called away for another meeting, and I said I would welcome you and your company on his behalf.

Ms. LARKIN. Thank you so much, Mr. Stark. Mr. Stokes sends his regards to you and to Mrs. Johnson as well.

Chairman JOHNSON OF CONNECTICUT. We are glad to have you, and certainly, Lou Stokes was one of our most impressive Members for many years and still highly regarded.

Mr. Steinberg.

STATEMENT OF MARK STEINBERG, SENIOR HEALTH POLICY ANALYST, FAMILIES, USA

Mr. STEINBERG. Thank you. Good afternoon, Madam Chairman, Mr. Stark, Members of the Committee. I thank the Subcommittee on Health for the opportunity to present testimony today, and my remarks today are going to focus on two particular issues with implementation. First, I want to talk primarily about enrollment in the low-income subsidy, which we have heard already some about, and then, I will turn very briefly to the issue of prices. I think we have discussed a great deal of that today, so I am not going to get into that in depth.

First, I want to speak about the low-income subsidy. This should be a happy topic. I think all stakeholders on this issue agree that the low-income subsidy is a real step forward for some of Medicare's neediest beneficiaries. For those who qualify, the subsidy limits cost sharing for most beneficiaries to a very minimal amount. Others will still have some coinsurance, but it is still substantially less than the significant cost sharing that other Part D beneficiaries have to pay.

Now, unfortunately, enrollment in this program has been so far extraordinarily disappointing. The most recent data we have available from the Social Security Administration shows that only about 1.6 million of the estimated 7 to 8 million beneficiaries have actually enrolled in the low-income subsidy. That is fewer than one out of four eligible, and this is a very disappointing result.

Now, CMS has taken a positive step recently and said that they will permit beneficiaries who enroll in the subsidy subsequent to May 15 to then join a Part D plan instead of having to wait until the next open enrollment period at the end of the year, and we applaud them for doing that. However, these beneficiaries will still be responsible for at least a partial late enrollment penalty.

Moreover, it is extraordinarily important that the Social Security Administration and other organizations use their resources to continue outreach and enrollment to low-income beneficiaries during this time. The other big player in this area are the State Health Insurance and Assistance Programs, the SHIPs, who have been doing work above and beyond the call of duty in the first few months, and they really need a great deal of help.

As the Chairman commented, one-on-one counseling is the best way to get people into the subsidy, particularly low-income beneficiaries; there are a lot of factors that they have to weigh and to have explained to them. SHIPs can do this job, but they need help. Right now, they are funded at less than \$1 per beneficiary, and we encourage Congress to take a look at that as well as to ensure that

Social Security Administration (SSA) has all the resources it needs to do the outreach.

In addition to doing more for outreach and enrollment, there are several legislative changes that we think could help reach low-income beneficiaries. The first, we understand, is a big one, but the assets test could be eliminated, if not this year, in the future. First of all, that would ease the enrollment process dramatically. It would allow automatic enrollment for beneficiaries, because you would simply have to look at their income, which is widely available through IRS records as opposed to having to do asset evaluations. It would also create a simpler application.

Short of that, Congress, we think, could advise that Social Security would no longer have to evaluate the cash value of a person's life insurance policy, which is currently counted as an asset, and the value of which is only obtainable through calling your life insurance company. This has been a stumbling block for beneficiaries. Also, Social Security continues to count in-kind support, such as if an adult child provides housekeeping for an elderly parent, that counts as income under the Social Security rules. We would like to see that eliminated. We think that could ease the process significantly.

I want to talk briefly about dual eligibles, although my colleague, Vicki Gottlich, will discuss that in depth. We know there were a great deal of startup problems at the beginning of 2006, in January and February dealing with technical problems, where the computer systems simply were not talking to one another. Some of those problems have been alleviated, and we are pleased to see that, but there are a great deal of structural problems that remain. We heard some today already about the differences between the Medicaid system and the new Part D system, and my colleague, Ms. Gottlich, will extend more on that.

Now, I would like to turn briefly to pricing, and I said I know we have heard a lot about it this morning or this afternoon, rather. We actually do not know what prices Part D plans have negotiated with manufacturers. That information is not provided. What we know is the prices that the plans then charge to the beneficiaries. That is what we at Families USA and other organizations have used to evaluate the prices that Part D plans have been receiving. We assume that they must be passing some of those savings on to beneficiaries, but it could be as little as one penny; it could be as much as a large share. We simply do not know that.

When Families USA did a study and examined what TDPs were charging in November, we found that the median prices compared to the VA were 48 percent higher for the top 20 drugs used by seniors. If Medicare brought that negotiating power that the VA has to Medicare, we would see some comparable savings in line with that.

Finally, we have seen that prices have continued to increase. We have looked at the top 20 drugs. We have seen a similar increase that really is in almost lockstep with average wholesale price since November. This means that plans are simply passing on any inflation they see to consumers, which suggests they are not seeing the kinds of savings that we had hoped they might see but have not so far.

I want to thank the Subcommittee for the opportunity to present this testimony and am happy to take questions.

[The prepared statement of Mr. Steinberg follows:]

**Prepared Statement of Mark Steinberg,
Senior Health Policy Analyst, Families USA**

Families USA thanks the Subcommittee on Health of the Committee on Ways and Means for the opportunity to submit testimony on the implementation of Medicare Part D, Medicare's prescription drug benefit. Our testimony focuses on three concerning aspects of implementation: enrollment in the low-income subsidy; the drug prices charged by the participating drug plans; and the transition of dual Medicaid/Medicare eligibles from Medicaid to Medicare drug coverage.

Disappointingly Low Enrollment in the Low-Income Subsidy

For those who qualify, Part D's low-income subsidy ("LIS") is potentially a very valuable help. Unfortunately, enrollment in the program has been a deep disappointment. According to the most recent data available from the Social Security Administration ("SSA"), only about 1.6 million of the estimated 7 to 8 million eligible beneficiaries have been signed up—fewer than one-fourth of those who qualify.

CMS has recently taken a positive step by announcing that those who enroll in the LIS after May 15 will be able to join a Part D plan at that time, rather than waiting for the next open enrollment period. These beneficiaries, however, will be responsible for at least a partial late-enrollment penalty. Nevertheless, the potential for additional enrollment after May 15 makes it very important that SSA and other organizations, including State Health Insurance and Assistance Programs (SHIPs) continue their outreach and enrollment efforts throughout the year. One-on-one counseling such as that provided by SHIPs can be very effective, but it requires the investment of substantial time and financial resources. Congress should insure that SSA and the SHIPs have all the resources they need to fund aggressive outreach. At least one recent report suggested that SSA may be under-equipped for its responsibilities.¹

In addition, changes to the LIS rules could ease the enrollment process. Eliminating the asset test entirely would go a long way towards streamlining eligibility determinations. It would also help those needy beneficiaries with limited incomes but who have managed to save a modest amount over their lifetimes. Short of a complete elimination of the assets test, Congress should make two simpler changes that would help the process by clarifying that: 1) the cash value of life insurance should not count as an asset; and 2) in-kind support (such as housecleaning by an adult child) should not count as income. These two questions slow the enrollment process and create additional burdens on beneficiaries.

Concerns About Plan Drug Prices

The third issue that we would like to raise is related to drug prices and price stability across participating Part D plans (PDPs). While this is not an issue limited to program implementation, any failure of the plans to obtain significant price discounts and pass those discount on to enrollees, as well as any failure to contain drug price inflation, has long-term implications for program costs to taxpayers and beneficiaries.

Under the law, the government is prohibited from negotiating for lower drug prices on behalf of Medicare beneficiaries on the premise that, through competition, the plans will obtain discounts comparable to any the government could. This assumption has not proven out.

Plans are not required to publicly report the drug prices they negotiate with manufacturers—which may well be quite low. The Medicare drug plans do, however, report the drug prices they are charging to beneficiaries. Those prices are significantly higher than the prices the government currently negotiates with drug manufacturers through the Department of Veterans Affairs. In fact, a Families USA study of November PDP prices for drugs frequently prescribed to seniors found that the lowest PDP price was in nearly all cases significantly higher than the lowest price negotiated by the Department of Veterans Affairs.² That study found the median price difference to be 48.2 percent. If the government were allowed to negotiate drug prices for the Medicare program, given the size of the Medicare population and their

¹ Email from Linda McMahon, Deputy Commissioner of Operations for Social Security, to Social Security Administration Operations employees, January 21, 2006.

² Dee Mahan, "Falling Short: Medicare Drug Plans Offer Meager Savings," (Washington, D.C.: Families USA, December 2005).

heavy prescription drug use, it should be able to achieve prices at least as low as those the Department of Veterans Affairs currently negotiates.

The drug prices charged by PDPs have a direct impact on beneficiaries, specifically those who do not qualify for extra help. Plan prices are used to determine when an enrollee meets the deductible, reaches the gap in coverage (the “doughnut hole”), and reaches catastrophic coverage and is eligible for higher government subsidies for the rest of the year. These are also the prices that enrollees must pay out-of-pocket during the “doughnut hole.” PDPs’ failure to negotiate low prices also has implications for premium increases in subsequent years. As a result, high PDP drug prices mean more costs to beneficiaries and to the program.

However, it is not just high prices that raise concerns. Plans can change the prices that they charge for prescription drugs at any time. Since the start of the program, many plans have increased drug prices, in many cases these increases have been in tandem with increases in manufacturer prices.

In the five months from November 15, 2005, when individuals could start enrolling in drug plans, to April 15, 2006, the median PDP price increase for frequently prescribed drugs was 3.7 percent.³ While there was considerable variation in price changes between individual plans, the median price change across all PDPs was nearly identical to manufacturer increases in average wholesale price. Beneficiaries are locked into a plan for a year, yet cannot rely on any sort of stability in that plan’s drug prices, which are a key factor in plan selection. Furthermore, as long as the plans are routinely raising prices in line with manufacturer price increases, they are not exerting any bargaining clout that can offer consumers protection from continuing drug price inflation.

Allowing the government to negotiate directly with manufacturers could both lower drug prices and bring price stability to the program. This would benefit beneficiaries and reduce overall program costs to taxpayers.

A Difficult Transition for Dual Eligibles

Dual eligibles are Medicare’s most vulnerable beneficiaries. These 6.3 million low-income seniors and people with disabilities are the only beneficiaries whose drug coverage was disrupted directly as a result of the start of the Part D program. Under the law, dual eligibles who did not select a drug plan before January 1, 2006 were to be automatically enrolled in a Part D plan selected at random, without regard to their specific drug needs. Prior to the start of the program, state Medicaid officials, advocates, and others expressed deep concerns about the ability of CMS and the other involved players to implement smoothly a transition of this magnitude.⁴

Unfortunately, these concerns proved well-founded. Thousands of the neediest beneficiaries were unable to obtain essential medications during the first months of the program. Problems with data exchanges between states, CMS, Part D plans, and pharmacists made it impossible to determine which plans dual eligibles were enrolled in, and what their cost-sharing should be. Ultimately, at least 44 states and the District of Columbia stepped in to respond to the emergency and use their old Medicaid system to provide a flow of medications to dual eligibles. CMS agreed in late-January to reimburse states for their expenses, although as of this writing, states have not yet been compensated.

Although some of the most egregious technical problems are easing, glitches remain. The basic structure of the Part D program will continue to create barriers for dual eligibles that will make them worse off than they were under Medicaid. First, in about half the states, co-payments for dual eligibles are higher than they were under Medicaid. Second, dual eligibles must now navigate formularies and utilization management rules that are generally much more stringent than preferred drug list policies under Medicaid. Many duals will likely continue to encounter problems obtaining needed drugs. The HHS Inspector General found, for example, that 30 percent of dual eligibles were assigned to plans that covered less than 85 percent

³Based on a Families USA analysis of PDP mail order prices from November 15 to April 15 for all plans operating in Regions 5 (Delaware, Maryland and DC) and 14 (Ohio). The analysis looked at the twenty drugs most frequently used by seniors, as outlined in Families USA’s report “Falling Short” (See Footnote 4 for a citation to that report). PDP price changes for those drugs were compared to changes in manufacturer average wholesale price (AWP) for the same time period. For 19 of the 20 drugs, the median percent change in PDP price was equal to any change in manufacturer AWP. For one drug, the median PDP price increased absent any manufacturer price increase.

⁴See, e.g. Vernon Smith, et al., *A Medicaid Perspective on Part D Implementation; The Medicare Prescription Drug Program* (Washington, Kaiser Commission on Medicaid and the Uninsured, December 2005); Andrea Cohen, et al. *MMA and Dual Eligibles: A Transition in Crisis* (New York: Medicare Rights Center, March 2005).

of the most commonly used drugs.⁵ Although dual eligibles can change plans monthly, finding a plan that comes closest to meeting their needs continues to be a daunting task, especially for those with cognitive impairments or complex medical needs.

We believe that taking action to deal with the issues and problems outlined in our testimony would be significant steps towards correcting some of the many issues that have arisen related to Medicare Part D.

We thank the Subcommittee for the opportunity to present this testimony.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Steinberg.

Ms. Gottlich.

**STATEMENT OF VICKI GOTTLICH, SENIOR POLICY ATTORNEY,
CENTER FOR MEDICARE ADVOCACY**

Ms. GOTTLICH. Thank you, Madam Chairman, Mr. Stark, and Committee Members for the opportunity to testify today. I am Vicki Gottlich, a senior policy attorney in the Washington, D.C. office of the Center for Medicare Advocacy. The Center is a national, non-partisan educational and advocacy organization headquartered in Connecticut. We represent thousands of individuals in Medicare appeals, respond to calls and e-mails, and provide support to CHOICES, the Connecticut State health insurance assistance program.

Our written comments include examples of individuals such as the person from Florida who is not getting his HIV/AIDS drugs, who face problems that should not happen under CMS guidance. They do happen. The amount of time it takes to resolve problems is enormous, and not all problems can be resolved.

CMS refuses to look at systematic issues, even though acting on systems issues might be the best way to resolve an issue. I would like to start with our client, Mary F. from Wilimantic. SSA told Mary that she was awarded the full, 100 percent low-income subsidy. However, CMS told her plan that she had a partial subsidy, meaning she has to pay 15 percent copayments. The Center got involved. We worked with CMS. We thought the issue was resolved, yet, last week, Mary was asked to pay a 15 percent copayment for a new drug again. She is a low-income individual. She cannot afford to do this. Additionally, she has been told that it may take up to 10 weeks to reimburse her for the payments that she has already paid in excess of what she should be paying. She cannot afford to do this.

Mary is not the only one who has encountered programs, even when they are working with the CMS caseworkers Dr. McClellan described in his testimony yesterday. Yesterday, we heard from a 44-year-old dual eligible individual from Illinois who told us that he had been auto-enrolled in a plan in December, then disenrolled and reenrolled so many times that he does not have drug coverage. He actually has contacted the plan, CMS, and SSA; been working with them; but each program blames the other, and the problem

⁵ Office of the Inspector General, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090 (Washington: U.S. Department of Health and Human Services, January 2006).

is not fixed. He has no drug coverage. He has to pay \$229 for drugs out of his \$710 a month income. He is not better off.

We also heard yesterday from a woman in Oceanside, California, whose autistic daughter, a dual, now must pay copayments she cannot afford to pay. She is one of the 1 million California dual eligibles who have to pay copayments for their drugs for the first time. In addition to the issue of copayments for dual and increased costs for duals, our written testimony talks about the Office of Inspector General study and talks about studies for California Health Foundation, which indicate that the drug coverage in Part D plans to which duals have been assigned is not extensive and does not cover the drugs that they need.

For some dual eligibles, enrollment in Part D means they may lose other health coverage. The Connecticut Department of Social Services (DSS) asked the Center last week about duals and their dependents who are losing retiree health coverage as a result of their auto-enrollment in a Part D plan. DSS said auto-enrollment results in a loss of access to health care for the duals, uninsured status for some family members, and increased cost for the State, since Connecticut will lose private insurance coverage to offset Medicaid.

I was interested, Madam Chairwoman, in your comments about the sixth-graders who are enrolling people in the plans, because I have also had the opportunity to enroll people in plans. It takes me at least an hour and a half to go through the Medicare Website, because you cannot just look at the lowest costs. You have to look at utilization management tools, prior authorization, quantity limits, step therapy, which are not easy to find. In addition, once you go through the Web finder, you have to contact the plans, and we are finding information we get from the plans is not always the same as the information on the Web.

Then, there are problems that we outline in our testimony about the exceptions process. The Center is one of the groups that worked with the American Medical Association and America's Health Insurance Plans to develop the standard forms. We are hopeful, but we understand that CMS guidance on these issues is not mandatory, and therefore, we are concerned that plans will not comply, which is really what happened with the transition process in the beginning of the year. We have followed CMS' guidance and reported the problems we encountered with plans to CMS.

What we are really concerned is that CMS may not take any action against the plans. We would very much like Congress to ensure that CMS exercises its enforcement authority against some of the bad actors that we have seen: plans that do not cover drugs that are in the six required classes of drugs; plans that interpret a 72-hour exception deadline as 72 business hours; plans that ignore requests for coverage determinations; plans that require doctors to fax a request form to get a request form so that they can get the exception request form that they need to start the appeals process.

Our written testimony includes numerous recommendations to various issues that we raise. Our overall recommendation is to include in Part D a single standard Medicare prescription drug ben-

efit, administered by Medicare that is uniform nationwide. Thank you again.

[The prepared statement of Ms. Gottlich follows:]

**Prepared Statement of Vicki Gottlich,
Policy Attorney, Center for Medicare Advocacy**

I am Vicki Gottlich, a Senior Policy Attorney in the Washington, D.C. office of the Center for Medicare Advocacy, Inc. (the Center). Thank you for the opportunity to testify at the continuation of the hearing on the Implementation of Medicare Part D.

Founded in 1986, the Center is a national, non-partisan educational and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The Center's national office is in Connecticut, with offices throughout the country, including Washington, D.C. The Center represents thousands of individuals in Medicare appeals each year, responds to calls and e-mails from individuals in Connecticut as well as from all across the United States, and provides support to CHOICES, the Connecticut state health insurance program. Requests to the Center for assistance have increased exponentially with the advent of Medicare Part D.

The White House and the Centers for Medicare & Medicaid Services (CMS), in their efforts to promote Part D, proclaim that "the new drug program is working well for most seniors (sic) and pays nearly all of low-income beneficiaries' drug bills." See, e.g., "The Medicare Prescription Drug Benefit: Helping Seniors and Reducing Costs," a Fact Sheet issued by the White House on March 14, 2006.

What they do not say is that many of the beneficiaries encountering problems are dually eligible for Medicare and Medicaid (dual eligibles). The barriers to their getting drugs that were previously paid for by their Medicaid programs are not temporary glitches but result from the very design of the Part D program. The Center avers, based on our conversations with Medicare beneficiaries, their families and their advocates, that this most vulnerable population is, as a whole, much worse off than they were before they were shifted from Medicaid to Medicare drug coverage.

Problems and recommended solutions include:

1. Dual eligibles have been randomly assigned to average-cost prescription drug plans, most of which do not cover all drugs commonly used by this population.

To ensure no gaps in coverage when dual eligibles transition from Medicaid drug coverage to Medicare drugs coverage, the Medicare Modernization Act provides for them to be randomly assigned to plans if they do not choose a plan on their own. Random assignment benefits Part D drug plans by guaranteeing them an equal portion of the enrollment of the dually-eligible population, without burdening them with too large a portion. Random assignment does not, however, benefit beneficiaries.

The Inspector General of the Department of Health and Human Services has determined that nearly one-third of dually eligible beneficiaries—a highly vulnerable population with unusually high medication needs—were assigned to drug plans that included less than 85% of the 178 most commonly used Part D drugs.¹ Some of the drugs excluded from a substantial number of plan formularies (lists of covered drugs) are drugs for high blood pressure, high cholesterol and pain relief.

Only 18% of beneficiaries were assigned to plans that covered all 178 drugs, but this does not mean that even these plans cover all drugs needed by each beneficiary—only that they cover the most commonly used drugs. Moreover, even plans that cover all drugs may have quantity limits, prior authorization and other barriers to immediate and full coverage of an individual beneficiary's prescription drug needs.

Other researchers came to similar conclusions after reviewing formularies of plans available in specific regions. For example, Jocelyn Guyer and Jeffrey S. Crowley of the Georgetown Health Policy Institute wrote a series of three policy briefs for the Connecticut Health Foundation. They found large variations in the extent to which the 44 stand-alone prescription drug plans available in Con-

¹ Office of Inspector General, "Dual Eligibles" Transition: Part D Formularies' Inclusion of Commonly Used Drugs," (OEI-05-06-00090 January 2006).

necticut covered medications, with major and frequent shortcomings in coverage of critical drugs used by dual eligibles.²

A 33 year-old beneficiary from Orange Part, Florida, described the difficulties experienced by dual eligibles in an e-mail sent to the Center last week:³

I have been on Medicaid since 1996, and Medicare since 1998. I get Social Security Disability, and I am below the poverty level. Since Medicare Part D., has kicked in. I have had to pay for medicines that Medicaid used to pay for, now I'm responsible for the co-pays of my medicines. I am a kidney transplant patient and have been a diabetic for 30 years. I also have been diagnosed with HIV in 2001. I can't pay for my medicine copays, because I make approximately \$8,500 a year. Even with the "extra help" that I get from Medicaid, I still have to pay about \$40 a month for medicines. However, my medical insurance doesn't cover my transplant medications or my HIV medications. These medicines cost about \$400, a month. What has the president done? Is there a plan to kill off the elderly and sickly, or do we just have to suffer the consequences? Thank you for letting me speak my peace.

Center for Medicare Advocacy Recommendation: In assigning beneficiaries to plans they have not chosen, more attention must be given to matching individual beneficiaries' drug usage and pharmacy preferences with the formulary and pharmacy networks of individual plans.

2. Getting coverage for drugs that are not on a plan's formulary involves engaging in one of several complex processes. The frailty of this population, including a high incidence of cognitive impairments, makes navigating those processes more difficult than for other beneficiaries.

Applying for an Exception. Each plan must have a process for enrollees to ask for an exception to non-coverage, and each plan's process is different. The Center is part of a group, spearheaded by the American Medical Association (AMA) and working in conjunction with America's Health Insurance Plans (AHIP), that has developed a model exceptions request form. Although CMS has posted the model form on its website, and AHIP members may post the form on their websites, CMS does not require the form to be used by the plans.

An exception request must include a doctor's statement that all drugs on the formulary are either less effective or harmful to the beneficiary or both. Some plans are requiring the submission of clinical notes verifying such assertions. Because each plan's process is different, physicians must deal with multiple processes to serve all their patients. Some doctors are charging for completing prior authorization and exception request forms. Dual-eligible beneficiaries who cannot pay even nominal fees for this service cannot avail themselves of the exceptions and appeals processes.

The problems that arise from trying to navigate the exceptions process are almost too numerous to include in testimony. The issues brought to our attention by Medicare beneficiaries, their families, and their advocates include:

- Not knowing that there is a process to request an exception or coverage determination;
- Not getting through to customer service offices;
- Customer service offices not being available to accept emergency calls from doctors outside of normal business hours;
- Not having the exception request treated as an exception because the beneficiary did not use the proper term;
- Having to fax or mail to a plan a preliminary request form in order to get the request form that will start the coverage determination process. Without a coverage determination a beneficiary cannot file an appeal;
- Plans not complying with statutory timeframes;
- Plans not forwarding cases to the independent review entity as required when time frames are not met;
- The independent review entity failing to conduct a new, independent review of the medical evidence.

Changing prescriptions. Plans encourage enrollees to change from an uncovered drug to one on their formulary. Such a change presumes that there is a drug on the formulary that would work as well as the uncovered drug. Making such a change may involve multiple visits to a doctor's office, each of which may cost money in terms of transportation and office visit co-pays, for the doctor to first

²The policy briefs are available at www.thehealth.org. Judith Stein, Executive Director of the Center, was a research contributor to the policy brief on Implications for dual eligibles.

³Beneficiary comments are verbatim and may contain grammar mistakes.

prescribe, and then monitor, use of the alternate drug. Duals often do not have the resources to pay for the transportation or the cost-sharing for such visits. Since many use clinics, they may not be able to get an appointment with a doctor before their medication runs out.

Changing to a plan that covers the drug in question. Unlike most Medicare beneficiaries, dually eligible beneficiaries are allowed to change plans whenever they want to, with their new coverage effective the month following their action to change. Changing plans, however, is difficult and not without risks. First, the number of average cost plans in each region ranges from six to eighteen and the systems available to help beneficiaries know what each plan covers require access to high speed Internet service and a printer. Few dual-eligibles use the Internet, so to make use of these decision supports, a beneficiary must generally get help from someone else. The programs that are funded to counsel beneficiaries are overwhelmed by people needing such assistance and by the many difficulties that have arisen during the first months of the program.

Moreover, processing new enrollments in a plan is complex, requiring communication between the old plan, CMS, the new plan, and another government contractor. The information takes days to weeks to run through the system; a change made toward the end of the month will not show up in the system until later the following month, making it difficult to purchase drugs in the first part of the month.

Finally, plans can change the drugs on their formularies at any time, with 60 days' notice to individuals taking the drugs in question.⁴ Even an intelligent choice of a plan covering all of a beneficiary's current drugs could be for naught, if the plan removed some or all of those drugs from its formulary two months later. An April 27, 2006 Memorandum from Abby Block of CMS to Part D Sponsors, "Formulary Changes during the Plan Year," suggests that plans continue to cover a drug for any plan enrollee who is currently taking the drug even after the plan removes the drug from its formulary for other enrollees. Unfortunately, this CMS Memorandum to exempt current enrollees from formulary changes involving their current drugs is *not* binding on any plans. This Memorandum, like the rest of the policy guidance issued by CMS to implement much of Part D, has not gone through the Administrative Procedure Act notice and comment rule-making process, and does not have the same legal effect as the statute and the implementing regulations.

The consequences to beneficiaries are enormous, as these client experiences demonstrate.

It was extremely stressful to get a plan picked out that would even cover my medicines, I'm disabled not old and every step of the way has been a battle. The insurance company STINKS. I have to fight for nearly every prescription. From getting the right generic to one they prefer. It's almost like they are my doctor, not the insurance plan. I have had to go the the ER several times because I was forced to wait or fight for meds that would have helped. I also have asthma and now they are denying my singulair, suddenly some crap about needing pre-approval. This is some of the worst insurance ever. Medicare Part D is one of the worst things the Bush administration has done.

—E-mail dated April 26, 2006, from a 35-year-old female in Hawley, Minnesota.

My other half has AIDS and our pharmacist suggested that we go with AETNA because it covers all his HIV meds as well as all the other meds he's on. So we signed him up for it and now it seems like each month they are not wanting to pay for certain non-HIV medications. They want him to take something else. One of those is to prevent him from getting pneumonia. It's Bactrum. Their formulary on-line says they will pay for it, but their letters keep saying they won't. After one month he's already into the catastrophic coverage part because of all the meds he's on. Every month it's a different story, a different medication is being denied. What gives them the right to play doctor with people's lives?

—E-mail dated April 26, 2006, from a 42-year-old male in Land o' Lakes, Florida
Center for Medicare Advocacy Recommendations:

- (1) Exceptions processes should be uniform for all plans, with a single form made available to all physicians and pharmacists;
- (2) Plans should be prohibited from removing drugs from their formulary during the plan year;

⁴Note that the regulations specifically allow Part D plans to change their formularies. 42 C.F.R. § 423.120(b)(5),(6).

- (3) More money should be made available to programs that provide individualized assistance to beneficiaries.

3. Plans' transition policies have been difficult to get and difficult to enforce at the pharmacy level.

Each plan is required to have a transition process to address the situations of new enrollees who are taking drugs not on the plan's formulary. The transition policies include special focus on the needs of dually eligible beneficiaries. While issues with transitions have been prominent in the early months of Part D because the entire program was "transitioning" into existence, transitions will occur every month as new enrollees join plans, and especially every January, after major plan shifting has occurred during the annual enrollment period in November and December.

CMS asked plans to extend the transition coverage of non-formulary drugs through the end of March, so that beneficiaries could get a 90-day supply. Such an extension was voluntary on the plans' part. And, even after the extension request, dually-eligible and other beneficiaries are coming away from the pharmacy with no prescription, or with just a few days' supply of pills.

Moreover, the transition is merely to allow the beneficiary to change drugs, change plans, or request an exception so that her drug can be covered even though it is not on the formulary. But many beneficiaries are not receiving the notices they are supposed to get telling them what they should do next. For example,

Center staff spent many hours during February and March 2006 helping a woman in California get coverage of a prescription that she had been taking for 35 years for a chronic condition. (Part of the problem was that the plan could find no record of her enrollment until mid-February.) She contacted us last week to say that, although she had received the prescription in February and March, the plan was once again telling her that the drug was not covered. We suspect that she got the drug in February and March under the transition process, and now the plan wants her to go through the exceptions process—again—to get her medically necessary drug.

A 58-year old male from Jellico, Tennessee commented to the Center via e-mail about the transition process:

I Called First Premier Health (my Provider For Part D to see if All My Medications Were Covered before I Signed on With Them, They Assured Me They Were, After 2 Month's They Wrote Me A Letter Saying that My (Pravachol) Was No Longer Covered, I Had to Try Alternative Meds First, Hell I've Tried Them All, Pravachol Works The Best For Me, I've Been On It For Over 4 Years Now!! This Does Not Make Any Sense!!! Thank You!! I Have Always been Taught When Something Works Real Well For You, Stay With It!!!!

Center for Medicare Advocacy Recommendations:

- (1) Transition policies should be uniform across plans and easily made known to beneficiaries and pharmacists;
- (2) Plan call lines, for pharmacists to get instruction to override codes, should be required to operate 24 hours a day, seven days a week;
- (3) CMS should enforce contract requirements of plans.

4. Dually eligible beneficiaries using long-term care services are treated differently depending on where they receive the services.

Dually eligible beneficiaries are provided the best Part D subsidy available under the law. They pay no premium (for an average cost plan) or deductible, have no coverage gap (doughnut hole) and no cost-sharing at all after they reach the catastrophic coverage threshold. Their co-payments vary from \$0 to \$5, depending on income or place of residence.

Dually eligible beneficiaries residing in nursing homes and certain other institutions have no co-payments, since they pay all but a very small amount of their income over to the institution that is caring for them. Dually eligible beneficiaries who are getting their long-term care services in assisted living facilities, board and care, and other similar community settings, however, are treated differently and may have co-pays as high as \$5 per prescription (for typically more than 10 prescriptions), even though they, too, must pay most of their income to their care provider and even though their care needs are similar to those of nursing home residents.

Center for Medicare Advocacy Recommendation: All dually eligible beneficiaries receiving long-term care services should be treated similarly and should have no

cost-sharing obligations, since most of their income is given over to the provider of service.

5. Dually eligible beneficiaries have lost Medicaid as secondary coverage.

The most common interrelationship between Medicare and Medicaid is that Medicare is the first payer for services and Medicaid picks up where Medicare coverage stops. This is not true under Part D. Medicaid is prohibited from paying for drugs that are covered by Part D. For a state to provide the kind of “wrap around” coverage that is typical for other services, it must use its own money, without any federal contribution. According to the Inspector General of the Department of Health and Human Services, only four states have indicated they will provide some kind of coverage for drugs that are not on a Medicare plan’s formulary.

Part D imposes prescription drug co-payments for the first time on a substantial number of dual eligibles, including the 1 million dual eligibles in California (approximately one-sixth of the dual eligible population). While the co-payments for duals are supposed to be minimal, for someone living on \$817 (100% of the federal poverty level for an individual) or less each month, \$3 per prescription is a fortune. As a beneficiary from New York wrote to the Center recently, she lives on Social Security disability benefits and cannot afford to pay the \$3 co-payment every time she goes to the pharmacy. In addition to California and New York—Florida, Texas and Illinois, which also have large dual eligible populations, are not providing any assistance with co-payments.

Even when states pay co-payments for duals, the systems do not always work. Despite the fact that Connecticut has legislated coverage of Part D co-payments for duals, a nurse from Marlborough, Connecticut writes that her mental health clients are still being charged co-pays.

I AM TRYING TO GET SPECIFIC INSTRUCTIONS FOR THEM TO BRING TO THE PHARMACY TO RESOLVE THESE ISSUES. SOME ARE TOO COGNITIVELY IMPAIRED TO DO THIS ON THEIR OWN.

For some dual eligibles who previously qualified for Medicaid on a “spenddown” basis, the advent of Part D means they will lose all of their supplemental health coverage.

A 60-year old client from Milford, Connecticut, who has Hepatitis C, has long alternated between Medicaid and ConnPACE, the state pharmacy assistance program, to help with prescription costs during his spenddown periods. He takes several very expensive medications and qualifies for the low-income subsidy. In fact, prior to Part D, when the entire cost of his medication—including the portion paid by ConnPACE—was applied against his spenddown, he usually met his spenddown obligation in less than one month. With the advent of Part D, only that portion which he pays—his \$2 and \$5 LIS co-pays—will count against his spenddown obligation. Our client correctly perceives that he will probably never meet his \$3,000 spenddown obligation at this rate. He currently is in need of an expensive medical test that he cannot afford, and is having difficulty finding a provider who will accept him as a patient as he no longer has Medicaid coverage and is unlikely to obtain it in the future.

For other duals, enrollment in a Part D means loss of all of their retiree health coverage, not just their drug benefit. A worker from the Connecticut Department of Social Services contacted the Center last week because dual eligibles are being notified that they and their dependents have lost retiree health coverage as a result of their auto-enrollment in a Part D plan. The worker wrote in her e-mail:

In addition to the issue of health care access for our recipients, former recipients, and dependents thereof, there are fiscal implications for DSS. Generally, DSS likes to use private insurance to offset Medicaid expenses. Using the automated process to enroll dual eligibles in Medicare D for recipients who have “creditable” prescription coverage is costly DSS.

Center for Medicare Advocacy Recommendation:

- (1) Amend the law to provide dual eligible coverage for prescription drugs, just as it exists for other health care services, including federal matching funds for state expenditures;
- (2) Amend the law to allow Part D drug costs, including the low-income subsidy, to count toward Medicaid eligibility based on spenddown.
- (3) Amend the law to protect duals and their families from loss of retiree health coverage as a result of enrollment in a Part D plan.

6. Individuals with Medicaid will experience a gap in prescription drug coverage when they first become eligible for Medicare.

Individuals with Medicaid lose their Medicaid drug coverage on the first day of the month that they become eligible for Medicare, even if they have not enrolled in a Part D plan. The state will transmit information about them to CMS when the state becomes aware of their new dual eligibility status. It is unclear, however, whether and when states will have that information. In addition, states often send information to CMS about new dual eligibles only once a month, generally at the end of the month. CMS may not be able to enroll a new dual into an eligible plan in time for drug coverage to begin the following month. CMS has indicated that Part D coverage will be retroactive, but it is unclear how duals will pay for their prescriptions while coverage and plan enrollment is being determined.

New dually eligible individuals can use the Point of Service (POS) option at the pharmacy that facilitates enrollment into the point of service contractor. The contractor will then inform CMS so that the individuals can be enrolled into a plan. Under the POS option, the pharmacy distributes a 14-day supply of medicine to the individual, with the possibility of an additional 14-day refill. Individuals who try to get prescriptions under this option at the beginning of a month may not have sufficient medicine to last until they are enrolled in a Part D plan.

Center for Medicare Advocacy Recommendation: Identify Medicaid recipients who are about to become Medicare eligible sufficiently in advance to auto-enroll them in a Part D plan before they lose Medicaid drug coverage. Alternatively, continue Medicaid drug coverage for these individuals until they are enrolled in a Part D plan.

Conclusion

Many of the problems and issues described above arise from or are complicated by the number of plans available and the fact that each plan has its own design, including formulary, transition processes, exceptions and appeals processes. Virtually no uniformity exists or is required.

Even after beneficiaries, their families, and their advocates spend hours and days on the phone trying to resolve issues with their Part D plans and with CMS, there is still no guarantee that the problem will be resolved. Our client, Mary F., from Willimantic, Connecticut, exemplifies the problem.

Mary F. gets by on limited income, and it is not unusual at the end of any month that she is down to her last \$5 in quarters for her laundry. She takes several medications, among them a pain reliever for severe gout. She is on ConnPACE and a Medicare Savings Program. She has documentation that she was awarded the full 100% low-income subsidy, and thus should be paying \$2 or \$5 for co-pays. However, Medicare has informed her plan that she qualifies for a partial subsidy, with 15% co-pays. Mary cannot afford to pay even ConnPACE's \$16.25 co-pays and, therefore, has gone without a new pain medication her physician prescribed a week ago. She is owed over \$70 in co-pay overpayments to her pharmacy and has been told it may take up to 10 weeks to be reimbursed. Despite repeated efforts on the part of the Center, as well as CMS's intervention in this case, the problem persists.

A Connecticut resident said it best in an e-mail from April 29, 2006:

I am on Ruby1 Healthnet subscriber. In 2½ months I have already used up my Medicare Part D. I will have to pay \$3349.56 out of pocket, before I qualify for Catastrophic Coverage. What a scam!!, another way to get into the middle class' pockets.

Overall Center for Medicare Advocacy Recommendations: Create a single, standard Medicare prescription drug benefit, administered by the Medicare program, that is uniform nationwide. Require CMS to oversee the program with mandatory due process standards.

Thank you for the opportunity to submit this written statement. We look forward to working with Congress to ensure that elders and people with disabilities have access to a meaningful and affordable Medicare prescription drug benefit.

Chairman JOHNSON OF CONNECTICUT. Thank you.
Mr. Vaughan.

**STATEMENT OF BILL VAUGHAN, SENIOR POLICY ANALYST,
CONSUMERS UNION**

Mr. VAUGHAN. Thank you, Madam Chairman, Members of the Subcommittee. If I could have my full statement put in the record, I would deeply appreciate it.

Consumers Union is the independent, nonprofit publisher of Consumer Reports. We do not just test toasters; we try to help people with what are safe drugs and good insurance policies, and we do strongly support some major reforms of Part D, as my first paragraph in the written statement details.

Pending major reforms, there are several key issues that would help make the program work better for consumers. We think the key to improving the current program is to make public the quality information that CMS should soon receive from the plans. This information starts coming in in 27 days, at the end of May.

The required reporting is all detailed in manuals sent to the plans last April and finalized this January. It is about a 12–14 page document that lists just all kinds of data that will be at CMS. Making this data public will let consumers make informed choices when selecting a plan, and this is particularly important this fall and next fall, when we are likely to see a lot of consolidation of plans. Give consumers information, and they will walk away from the poor plans and reward the good ones.

CMS is to be congratulated for requiring an extensive set of data and proposing even more data for next year. Yet, data collected but not made public does nothing to empower consumers. The attachments to my testimony detail our efforts to nail down what data will be available and when, and we thank CMS for working on this at a very high level with us. On April 25, we received a letter, and it is attachment number three in my statement with the CMS logo on it, and I would urge you to look at the bullet points in that letter. Frankly, they are kind of disappointing. The first bullet, the call center data, will be interesting, but the other three bullets mentioned in the letter seem, well, frankly kind of givens. Of course, those other three items should be happening, or a plan should not be allowed to continue in the program.

So, therefore, we urge the Subcommittee to request that in addition to call center performance data that CMS make information public as soon as possible on the generic dispense rate, the number of grievances and appeals filed per thousand people, the resolution of those, pro or con the consumer, and the number of prior authorizations, step therapy, tier, and nonformulary exception requests received per thousand enrollees. That would really help consumers.

We are not asking for new data. This is information that Medicare is already scheduled to collect starting at the end of the month. We are simply asking that it be made public.

Switching subjects, we are pleased that the Administration frequently mentions, as Dr. McClellan did yesterday, Consumer Union's efforts to educate the public about safe, effective, and lower-cost generic drugs. This is part of our BestBuyDrugs.org campaign, and I have attached a sample of that work at the back of my statement. We hope you will let your constituents know about it. It is a free service, free, really good stuff. If you would

like samples for a town meeting or event, we would be happy to provide them.

As the Administration says, if people aggressively use these kinds of shopping guides, they can save thousands and thousands of dollars. That is true, whether you are in Medicare or out of Medicare, whether you are a 20-year-old or a 64-year-old, it does not matter. You can save a lot of money through the aggressive use of generics.

CMS is to be commended for its recent guidance designed to stabilize formularies while encouraging the move towards generics. No action was taken, however, on the serious problem in many plans of constantly changing costs of drugs that are on the formulary. We think consumers need to be told more clearly that if they enroll in a percentage copay plan, they are likely to see a great deal of instability.

We have been monitoring five drugs in five ZIP Codes in big States for the last four months and are pretty shocked by the amount of movement. Sometimes, it is downward, which is great for consumers. Sometimes, it is up. There is a lot of movement, and I think a lot of seniors will feel that is a kind of “bait and switch” or “gosh, why did I spend so much time shopping when it keeps changing on me?”

So, if CMS could publicly say, “In this plan, X percent of the drugs changed during the last year,” it would help people select whether they want stability or whether they are willing to have an adventure when they go to the drug stores.

Thank you very much for your consideration of these recommendations.

[The prepared statement of Mr. Vaughan follows:]

**Prepared Statement of Bill Vaughan,
Senior Policy Analyst, Consumers Union**

Madame Chair, Members of the Subcommittee:

Thank you very much for the opportunity to testify.

Consumers Union, the independent, nonprofit publisher of *Consumer Reports*,¹ strongly supports major reform of the new Medicare prescription drug program (Part D). We believe that the current structure of the program will always be too confusing for seniors and people with disabilities, and be subject to plan abuse and adverse selection. We also believe that the program is too expensive for beneficiaries, taxpayers, and future generations, and that we must find a way to obtain lower-cost pharmaceuticals. Therefore, we support major amendments to the law that would provide for the option of a Medicare-administered, dependable, reliable, standard plan in which Medicare negotiates (much like the Department of Veterans Affairs) to get lower-cost pharmaceuticals.

Pending those reforms, the key to improving the current program is to give beneficiaries the quality information that CMS should *already be collecting from plans*, so that consumers can make informed choices when selecting a plan. New enrollees (e.g., people turning 65) should have this information in order to make the best initial selection. All beneficiaries should have this information to use in this fall’s open enrollment season (November 15–December 31, 2006) so that they can have some comparative standards by which to judge the plan they chose (or were auto-enrolled

¹ Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union’s income is solely derived from the sale of *Consumer Reports* and *ConsumerReports.org*, its other publications and from non-commercial contributions, grants and fees. In addition to reports on Consumers Union’s own product testing, *Consumer Reports* and *ConsumerReports.org*, with approximately 6.5 million combined paid circulation, regularly carry articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union’s publications carry no advertising and receive no commercial support.

in). Making the full range of collected information public is particularly important this first year, because Medicare has not been able to start the consumer satisfaction survey called for in the law.

CMS is to be congratulated for requiring an extensive set of data from the plans. The first quarter of data must be reported by the end of this month. The agency is also to be commended for proposing to improve those data requirements for plan year 2007 (see attached letter commenting on those proposed changes).

Yet data collected, but not made public, does nothing to empower consumers.

On January 5, we asked CMS for information on exactly what data would be made public and how soon. We thank CMS for a number of personal, high-level meetings to explore how this should be done. On April 25, we received a letter describing four issue areas where information would eventually be made public. On May 1, we responded to that letter (see attachments).

As our May 1 letter mentions, Consumers Union is encouraging beneficiaries to report on their Part D experiences, good or bad, through a 'Share Your Story' website (<http://www.consumersunion.org/issues/medicaredrugs.html>). We have received some reports of absolutely abysmal service and quality. We hope to increase the number of stories on that website to provide ideas for administrative and legislative reform, and as guidance to consumers. But consumers need more than anecdotes, they need the CMS's large database of quality indicators to make the best decisions.

We urge the Subcommittee and Congress to request that in addition to call center performance data, that CMS make information public as soon as possible on:

- the generic dispense rate;
- the number of grievances and appeals filed per 1,000 enrollees;
- the resolution, pro-consumer or anti-consumer, of appeals;
- the number of prior authorization, step therapy, tier, and non-formulary exception requests received per 1,000 enrollees (Section VI of the January 25, 2006 Reporting Requirements).

We are not asking for new data—this is information that Medicare is already scheduled to collect, starting May 31st. We are simply asking that this collected data be made public.

We are pleased that the Administration frequently mentions—as Dr. McClellan did in his testimony before you yesterday—Consumers Union's efforts to educate the public about safe, effective and lower cost generic drugs. This is part of our BestBuyDrugs.org campaign. I've attached a sample of that work. We hope you will let your constituents know about this free service. As the Administration says, if people aggressively use these kinds of shopping guides they can save thousands and thousands of dollars—whether they are in Medicare, Medicaid, uninsured, or in the private sector.

CMS is to be commended for its recent guidance designed to stabilize formularies (while encouraging the movement toward generics). No action was taken, however, on the serious problem in many plans of the constantly changing cost of drugs that are on the formulary. And we also think consumers need to be told more clearly that if they enroll in a plan with a percentage co-pay, they are likely to see a great deal of price instability. If beneficiaries want price stability during their year of enrollment, then they should be strongly warned to join plans with a set dollar co-payment (e.g., \$10 per generic; \$20 per brand) and avoid plans that offer percentage co-payments (e.g., 20 percent of plan price for brand).

Each month this year we have monitored all the plans offered in one zip code in each of five large states. Monthly, we have checked the price of a consistent package of five commonly used prescription drugs offered by 40–50 plans in these zip codes. Each month, we have seen a lot of price movement: sometimes down (which is good for consumers), sometimes up (which is disappointing). But we are continually surprised by the number of changes and the price volatility. We believe that many people sign up for a plan for a year and expect some dependability and stability during that year. It would help consumers pick plans in future open enrollment seasons if the degree of price increase (and formulary) instability is documented (for example, of 1,000 drugs on a formulary, 300 of them increased in price at one time or another). We urge CMS to make this kind of data available to consumers before each open enrollment season.

Thank you for your consideration of these recommendations.

Attachment 1*April 3, 2006*

The Honorable Mark McClellan
 Administrator
 Centers for Medicare and Medicaid Services
 PartDplanreporting@cms.hhs.gov
 Washington, DC

Dear Dr. McClellan:

Thank you for the opportunity to comment on the *Draft Medicare Part D Reporting Requirements for Contract Year 2007*, Updated 02/23/2006.

The key to all of these reporting requirements, of course, is that they be made public both quarterly and annually so that Medicare beneficiaries can have the latest information on the relative quality of the different Plans and Sponsors so they can make informed enrollment decisions. As per our letter of January 5, we continue to hope that as much information as possible will be made public before this fall's open enrollment season. All the reporting in the world will do no good, if it just sits buried in CMS files.

Congratulations on the Draft for 2007.

It provides some major increases in the 'granularity' or detail of the 2006 data, and will help the public and advocates understand better how the low income and most vulnerable are being served in the various Plans. It will require important information on how well Plans deal with transition formulary issues (clearly a major problem this winter). The increased information about possible conflicts of interest in the plan Pharmacy and Therapeutics (P&T) Committees is important and will help ensure 'good-for-patient formularies'—not just 'good for Plan-profits' formularies.

The addition of information on the 'number of pharmacy transactions rejected due to need for prior authorization' will be especially helpful to consumers in understanding which Plans require the least hassle—and which Plans to avoid.

The additional reporting requirements for Plan Call Centers are excellent. The failure of Plan call centers is a major source of frustration, and Consumers Union has received a number of complaints about unbelievably poor service at these centers. Attached is one example sent to us from a XXX enrollee. Enrollees in other Plans have reported similar problems.

We suspect that you will receive comments from Plans opposing these expanded reporting requirements. We hope you will stand firm with your Draft proposal: far too many Plans have woefully failed to prepare for and staff for the new benefit and they have contributed mightily to the rocky start of this important program. They have not earned the consumers' trust and therefore expanded reporting requirements are totally in order.

Thank you for your consideration of these comments.

Sincerely,

William Vaughan
 Senior Policy Analyst

Attachment example deleted:

Attachment #2*January 5, 2006*

The Honorable Mark McClellan, MD
 Administrator
 Centers for Medicare and Medicaid Services
 Washington, DC 20201

Dear Dr. McClellan:

Consumers Union is interested in what information may be available to consumers in the early fall of 2006 regarding the performance and quality of various Medicare Part D providers (including MA-PD plans).

It would be a great help in our work if CMS could inform us exactly what information will be available prior to the next open enrollment period that will speak to consumer satisfaction, quality performance, etc. For example, the law calls for consumer satisfaction surveys (1860D-4(d)). Will they be conducted in 2006 and be made public before the open enrollment period? If so, what satisfaction issues will be measured?

In addition, the enclosed "Final Medicare Part D Reporting Requirements (Updated: 04/18/2005) lists a number of items that are to be reported, with many of the first quarterly reports due at the end of May. Will this data be made available publicly as it is received? If not, what data will not be publicly released?

Thank you very much for your assistance in this request.

Sincerely,

William Vaughan
 Senior Policy Analyst

Attachment #3, CMS response to the above letter

Retyped copy of original letter, for inclusion in electronic file

CMS

DHHS

CENTER FOR BENEFICIARY CHOICES
Apr. 25, 2006

Mr. William Vaughan
 Senior Policy Analyst
 Consumers Union
 1666 Connecticut Avenue, NW, Suite 310
 Washington, DC 20009

Dear Mr. Vaughan:

Thank you for your inquiry on behalf of Medicare beneficiaries seeking information on the performance of Part D plans. The Centers for Medicare & Medicaid Services (CMS) would like to demonstrate to our beneficiaries that we are continually raising the bar on the level of quality of service we provide.

In promoting this vision on performance improvement, we are pleased to announce that metrics related to the performance of Part D plan sponsors are being planned for the near future. These metrics will address four areas: effective customer service, effective exceptions/appeals, effective data systems, and effective pricing.

- Effective customer service will address a Part D Sponsor's ability to provide superior service to beneficiaries and to pharmacists. Excellent performance in responding to inquiries and issues helps to ensure a high level of beneficiary satisfaction. Therefore, ensuring that Part D sponsors are meeting standards related to low call abandonment rates and a high percentage of calls answered within a short time are a priority of CMS;
- Effective exceptions/appeals will be monitored via complaint data and data from the Independent Review Entity (IRE). Ensuring that appropriate exceptions and appeals processes are being followed is crucial to providing beneficiaries access to the prescription medications they need;

- Effective data systems will measure Part D sponsor's ability to process data files in a timely manner; and
- Effective pricing will focus on Part D sponsors ability to provide accurate pricing data for the Medicare Prescription Drug Plan Finder and to ensure formulary synchronicity between approved formularies and the formularies displayed on the Medicare Prescription Drug Plan Finder.

The release of these data will be completed in phases. However, please be assured that CMS is committed to ensuring Plans meet the statutory requirements as set forth by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Sincerely,

Cynthia Tudor, Ph.D.
Acting Director
Medicare Drug Benefit Group

Attachment #4, Consumer Union response to above CMS letter

May 1, 2006

Dr. Cynthia Tudor
 Acting Director
 Medicare Drug Benefit Group
 CMS
 Baltimore, MD

Dear Dr. Tudor:

Thank you very much for your letter of April 25th (copy attached) providing information about the schedule of the types of data that will be made available to help Medicare beneficiaries choose a prescription drug plan, either as a new enrollee or during this fall's open enrollment season.

The letter is certainly helpful. Public information about the quality of plan call centers is certain to improve service in that area. A small survey we have on our Consumers Union Website where we ask people to 'share their story' about the plans has brought us some dramatic examples of poor service, often centered on non- or mal-functioning call centers.

The other three items listed in the letter are very important, but—and this is said with great respect for the enormous task and burden the agency has been through in the last two years—they are fairly self-evident. The plans should be following an appropriate appeals process, processing of appeals should be timely, and the data on prices and formularies should be accurate. If a plan is failing to carry out these fundamentals, then we hope the plan will not be allowed to continue in Medicare in 2007.

In terms of consumers making a choice, there is a great deal more to this program than the quality of the call centers. Medicare has been unable to conduct the consumer satisfaction surveys called for in the law. Therefore, we hope that additional plan quality information can be made public as soon as possible, and certainly before the advertisements for the new plan year (roughly October 15, 2006). Specifically, we hope that more information can be provided on plans:

- Generic dispense rate: Dr. McClellan and others in the Administration have repeatedly cited a Consumers Union study that showed how beneficiaries could save thousands of dollars, and perhaps avoid falling into the 'donut hole,' if they considered the use of generics that are as effective and safe as brand-name drugs. Giving consumers information on the 'generic dispense rate' that CMS is already collecting will help beneficiaries understand which plans may provide the most financial relief. This information is particularly important because we note that the final version of the anti-fraud manual unfortunately deletes language calling for plan pharmacy and therapeutics (P&T) committees to have members who are free of conflict from pharmacy benefit managers. Dropping that conflict of interest ban may increase the influence of PBMs in a plan's formulary, and result in the listing of brand-name drugs that offer a larger rebate (profit) to the plan, rather than generics that are a better bargain for consumers.
- the number of grievances received per 1,000 enrollees;

- the number of prior authorization, step therapy, tier, and non-formulary exception requests received per 1,000 enrollees;
- the number of appeals/exceptions it receives per 1,000 enrollees, and
- the resolution of those appeals (pro- or con-consumer).

The sooner quality information *that CMS is already collecting* is made public, the sooner plans will seek to improve their performance, and the sooner customers can make informed decisions when selecting a plan.

Thank you for your consideration of these additional requests.

Sincerely,

William Vaughan
Senior Policy Analyst
Consumers Union

Chairman JOHNSON OF CONNECTICUT. Thanks very much.

Thank you very much, Mr. Vaughan, for those practical suggestions. I think all those things are worth our attention.

Ms. Gottlich, just to move through quickly, do you think that drugs are an entitlement under Medicaid?

Ms. GOTTLICH. Under Medicaid?

Chairman JOHNSON OF CONNECTICUT. Yes.

Ms. GOTTLICH. Do I think that drugs are an entitlement under Medicaid?

Chairman JOHNSON OF CONNECTICUT. Correct.

Ms. GOTTLICH. I think that health care is an entitlement to everyone, but—

Chairman JOHNSON OF CONNECTICUT. I am talking about under the law.

Ms. GOTTLICH. Yes, I do, actually. There are drugs that are required under Medicaid, and some are optional.

Chairman JOHNSON OF CONNECTICUT. Let me make clear that under Medicaid that drugs are an optional benefit that States may offer. Let me also make clear for those of you who think that the State programs are so terrific that in California, you can have a maximum of six prescriptions a month. Think what that would do to seniors. Think how much better off seniors on Medicaid are—

Ms. GOTTLICH. Mrs. Johnson, when we raised this issue with advocates across the country, they cheer when we say that Medicaid beneficiaries, dual eligibles are worse off. At a meeting of the National Academy of Elder Law Attorneys two weeks ago, before 300 people, when I made that statement, people cheered.

Chairman JOHNSON OF CONNECTICUT. Ms. Gottlich, if you will suspend for a moment, I am making some comments. I want to move through my time and not use more than my 5 minutes.

Ms. GOTTLICH. Okay; that is fine.

Chairman JOHNSON OF CONNECTICUT. The point that I am making is that Medicaid program after Medicaid program in this country limits the number of prescriptions, limits the dollar value those prescriptions can cost. Medicare Part D is the first entitlement to prescription drugs that any poor group, much less any group, have had under a publicly funded policy, and I am very proud of that.

As many of you have pointed out, it is a very important step forward.

Ms. GOTTLICH. Let me point out to you that the State of Connecticut is one of the few States that has decided with State funds to reimburse—

Mr. ENGLISH. Regular order.

Chairman JOHNSON OF CONNECTICUT. I appreciate that, and I like that, but not all of the States have offered to do that. It is also true that our taking on the drug costs of Medicaid-eligible seniors is going to save States a lot of money, and I hope they will use it to do what Connecticut and Pennsylvania and other States have done; that is, to accommodate the level at which subsidies phase out.

So, we go above the 150 percent of poverty mark up to 225 percent of poverty mark, and this Subcommittee made all those States' payments count so that none of those people are ever affected by the cap. That is the opportunity the States have to use the money we are saving them, not only under Medicaid but for their State retiree, State employee retiree programs, which we also subsidize. So, this is a big win for States. They have an opportunity to adjust that spend-down level, and I hope that they will take it.

Now, there are a couple of other points I wanted to make. First of all, Ms. Larkin, thank you very, very much for the aggressive efforts of your company in outreach. Indeed, the partnerships that you have established, I think it is fair to say, are partnerships that United has never established in reaching out with their regular health care plans; is that not so?

Ms. LARKIN. It is correct. One thing we found about Part D is—

Chairman JOHNSON OF CONNECTICUT. Unfortunately, I have very little time.

Ms. LARKIN. Okay.

Chairman JOHNSON OF CONNECTICUT. So, I just wanted to note that about your testimony, that you have developed, and you have helped us develop, a depth and breadth of partnerships. You mention working with Jesse Jackson; absolutely wonderful, and he says over and over again on the radio, sign up.

On the other hand, Ms. Aronovitz, I do find some of the things that GAO did really quite questionable, and I will only have time probably for one comment, but the way you judged readability, it seems to me inferior to the way CMS dealt with readability. The traditional testers of readability rely heavily on counting syllables: deductible, formulary, prescription, all those words have multiple syllables, and they come out poorly by those raters.

If the test is also looked at from the kind of criteria that companies that specialize at looking at the clarity of message, navigational clues, and graphic elements, then, it is very clear, and the CMS has won national awards for the quality of their work.

Now, unfortunately, you are not going to have time to answer, because as Chairman, I wanted to flip through a lot of comments that were made, and I have to stay to my 5 minutes. I will listen to the comments of others, and afterwards, I will be happy to listen. I do feel we have to conclude the hearing so that people can get on their planes.

So, I will yield now to Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

I did want to make some semantic corrections. Once Medicaid offers a prescription drug program, it cannot be revoked, and so, therefore, it is an entitlement, and every State in the union has offered drugs under Medicaid, and therefore, it is an entitlement. On the other hand, Part D is not an entitlement to drugs. It is an entitlement to purchase insurance, and there is a vast difference between that and the entitlements as we know them under Parts A and B.

I would like to follow up with Ms. Gottlich. In terms of the low-income seniors, who we are mostly trying to help, do you think, given, as I think, the only option that we have in 2006 is the possibility, remote as it seems now, for an extension of the signup period. For the very low-income, it looks like they will be accorded that and not have to pay the penalty. Is that sufficient to deal at least with the lowest income of our prospective beneficiaries?

Ms. GOTTLICH. Well, Mr. Stark, Mr. Steinberg and I have had a conversation before the hearing began, and though CMS has said or indicated that the very low-income people would not have to deal with the penalty, we have not seen anything in writing from CMS, and so, if you have anything in writing from CMS that they would not have to pay a penalty, we would appreciate that.

We are hearing from people—yesterday, I got a call from someone in Nevada who cannot get an appointment with his State Health Insurance Assistance Program by May 15, because they are all booked up, which means that individual may have to choose a plan without having the assistance he needs, and he may not be in the best plan for him. Extending the deadline certainly would help somebody like that who is making the efforts that he needs to make.

Mr. STARK. Thank you.

Ms. Larkin, Mr. Vaughan suggested, and I concur, and I hope the Chair would join with me in requesting of CMS that the non-proprietary financial information, except the other information that will be required from the major plans in terms of appeals and this sort of thing, do you see any objection to our having that information as part of our continuing oversight activities?

Ms. LARKIN. I do not, Mr. Stark. I think because this program is new, the amount of information, including the financials and what it has taken to administer the program is important to this Committee, so we do not.

Mr. STARK. Okay; do you think—my guess is, and I just want to make sure—that some of the plans might not be very comfortable with some of the income and expense requirements, but—

Ms. LARKIN. I cannot answer for all—

Mr. STARK. I do know as it would help us. I am not sure that is our role, but the interest that we would have and I think that Mr. Vaughan is suggesting is how difficult is it for people under appeal to get a drug that maybe they have to go back to their physician and come back and how much time, and that sort of information, as far as you are concerned, you would feel comfortable with our having as part of our oversight program.

Ms. LARKIN. We would.

Mr. STARK. I appreciate that answer, and I hope, Madam Chair, that we could get that and, as Mr. Hulshof has suggested, I think we could deal with it in camera if necessary but in a nonpartisan way to find ways where we might choose, after the election, to see whether there would be minor changes in the program.

I wanted to ask Mr. Steinberg if you thought that the extension of the signup period, say, until 2007, as many of us have suggested, would do much to expand the participation in the program.

Mr. STEINBERG. I think it would help. I think it would, if nothing else, make the message much easier. Right now, if we have enrollment for low-income people after May 15 but not for others, it becomes a more complicated message for beneficiaries. If there is a simple, clear message saying you have more time, everyone has more time, we could reach more beneficiaries, particularly the neediest, who really could be helped by this program.

Mr. STARK. I want to thank you. My time is about up. Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Mr. Johnson, would you like to question?

Mr. JOHNSON OF TEXAS. Yes, thank you. Thank you, Madam Chairman.

I would like to ask the GAO, I know you were invited to our meeting yesterday, and then, the minority pulled your invitation. Why were you invited today?

Ms. ARONOVITZ. Well, I am not exactly sure why I was invited or not, but I think we do have a very important message, and I think we have done a study that has very high integrity, and if you have a minute, I would like to respond to the Chairman's comment, because I do think that more explanation is required.

Mr. JOHNSON OF TEXAS. In what area?

Ms. ARONOVITZ. This is the area of the written materials, where there was some concern about our methodology, that we used a readability methodology that was one that was not accepted in the field. I would like to just say that we were very conscious of the fact that some experts do not believe that readability, as we defined it, was sufficient in terms of really looking at grade level.

The first thing we did to make sure that we had the highest integrity in our work is that we adjusted for 26 words that CMS told us they could not substitute. So, our studies and the scores that we report are adjusted for making words like deductible, formulary, prescription, insurance, one-syllable words. We are treating it like it is an "and" or a "the."

Mr. JOHNSON OF TEXAS. Are you suggesting that the American public does not know how to read?

Ms. ARONOVITZ. No, I am not. I am suggesting that in studies where you do readability studies, one of the criticisms is that when you have multisyllabic words, that it complicates comprehension. Well, we made up for that.

Mr. JOHNSON OF TEXAS. You are criticizing our school system, our educational process, not the questionnaire.

[Laughter.]

Mr. JOHNSON OF TEXAS. I think that is enough. I would like to ask a different question.

Ms. ARONOVITZ. Okay.

Mr. JOHNSON OF TEXAS. Of United, you also were invited and declined and then said you would come yesterday, and then, you did not. Now, can you tell me why you are here today?

Ms. LARKIN. Well, I apologize for scheduling difficulties that may have occurred. Part D is important to our company, and so, we are pleased to be here today, and we will come back as often as the Subcommittee needs.

Mr. JOHNSON OF TEXAS. I appreciate that. I appreciate your testimony as well.

Consumers Union, you guys publish a magazine, do you not?

Mr. VAUGHAN. Yes, sir.

Mr. JOHNSON OF TEXAS. From what I can tell from some of your comments, you are telling people that if they buy your magazine, they can find out how to get cheaper drugs; is that true?

Mr. VAUGHAN. No, that is a free service. The BestBuyDrug.org, you do not have to buy that at all. We got a separate grant from the Engleberg Foundation and the National Library of Medicine out at the National Institutes of Health to help take this best evidence-based medicine that is being developed out in Oregon Health and Science University, where they look at what is the safest and best drugs; they avoided Vioxx and that kind of thing. The reports that come out of there are written in doctor Greek. They are very complicated.

So, what we do is we translate them into one-syllable words, and then, we match a price, a national price, and then, we look and say this is safe, this is effective, and this is the best price. If you look at the last sheet, sir, you will see why maybe the purple pill ads that you see on TV are not the best deals for you.

Mr. JOHNSON OF TEXAS. Okay; thank you, and I would just like to make one other comment as concerns the extension of time.

You know, yesterday, one of the guys said maybe we ought to extend Christmas to January 1 so we could finish our shopping before the deadline, and that is exactly what we have in this situation.

Thank you, Madam Chairman.

Chairman JOHNSON OF CONNECTICUT. Mr. English.

Mr. ENGLISH. Thank you, Madam Chairman.

Mr. Vaughan, it is a privilege to have you here, because I am very familiar with your publication. I do intend to review in detail your recommendations.

I guess my first question is if we adopted all of your recommendations, what impact would that have on the pricing of this particular benefit, including the cost of the premium as you might estimate it or the cost to the taxpayer?

Mr. VAUGHAN. All of this information is already coming in to CMS. The plans, when they signed up, committed to deliver this. These are deliverables.

Mr. ENGLISH. So, it is really a transparency issue.

Mr. VAUGHAN. It is a transparency issue. I think what you would get is you would get consumers saying well, I am not the only one who had trouble, and my neighbors did, but this plan over here is better, and there is less hassle, and I am going to move to that guy. Their generic dispense rate is better, and it is a better

deal. You would have informed consumers rewarding the good players and avoiding the turkeys.

Mr. ENGLISH. Well, as someone who supports a choice-based model for health care and who thinks that providing choices for people, provided that they get the consumer information is a preferable model and allows people to customize their benefits, I like your suggestion, and I am very much going to follow through with it and also consider following through with CMS on it.

Mr. VAUGHAN. Thank you.

Mr. ENGLISH. I guess my other questions have to do with—your contention is that the benefit is costing seniors money at some level is my reading of your testimony. How do you react to the recent figures showing that on the average, seniors will save \$1,100 under the benefit? Do you support the figures that we have that suggest that those eligible for low-income subsidies will save about \$3,700 on the average? Are those savings not fairly substantial for a benefit of this sort?

Mr. VAUGHAN. Absolutely, sir. I think those numbers are correct. The question is that within 24 months, this Subcommittee, under Title VIII of the Medicare Modernization Act (P.L. 108-173), is going to have to vote for major, major, major cuts in Medicare. We think you can get a better price for pharmaceuticals, a better drug program, and as you face this Title VIII forced vote because of the 45 percent rule, please do not shift more costs onto the seniors and the disabled, when we can get a better price for drugs than we are currently getting, that is what we are urging.

Mr. ENGLISH. I take your point, but I also do not think that that is the draconian choice that we are facing. I really think there are a number of ways that we can deal with it.

I also am curious about your reaction to the fact that premium costs are clearly substantially below what the original estimates were. We were operating off of an estimate that premium costs were going to be in the range of \$37 per month, and in fact, they have turned up at \$25 a month, and in some cases, people are eligible for—particularly in the low-income category, for savings, like I said, around \$3,700 with no gaps in coverage.

I wonder, is that not a fairly comprehensive benefit?

Mr. VAUGHAN. Well, absolutely, but again, this is a new \$8 trillion unfunded liability in the long run. Could we get a better deal? We are trying to get consumers and taxpayers the best buy.

Mr. ENGLISH. I take your point. Honestly, Mr. Vaughan, given the fact that we have set up a benefit in which the networks themselves are seeking discounts, in which they are going to be under market pressure to generate savings? They are able themselves to engage the pharmaceutical companies.

You know the curious thing about this whole debate is the notion that there is no negotiation going on. In fact, there is evidence of lusty negotiation. We have hospitals now who are lobbying us to be guaranteed the same prices that these plans have been able to leverage out of the networks. So, I guess what I see out of this is some expect points, some excellent points consistent with the difficulty of implementing this comprehensive plan, consistent with the experience that not a lot of people have this length of institutional memory, not even Mr. Waxman, but it seems to me that

back in the 1960s, when we were implementing the original Medicare plan, we have a lot of the same pains, and that was not really an argument against Medicare itself.

Do you have any other comment on that?

Mr. VAUGHAN. I think all large Federal programs have a rocky start, and it is a matter of trying to get them to work better very quickly. Oversight hearings like this are key to it, because it does catch the agency's attention, and I commend you for it and hope you can do more.

Mr. ENGLISH. Thank you for your recommendations.

Mr. VAUGHAN. Thank you.

Mr. ENGLISH. Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Mr. Doggett.

Mr. DOGGETT. Thank you.

Ms. Aronovitz, thank you so much for your professionalism and the way that your study was conducted. If I understand, one of the findings that you made that has not received attention here today on what I consider to be perhaps the most critical and basic question: when calls were made by the GAO to Medicare to ask the simple question of which plan will offer the lowest cost for individuals who have a given list of drugs, if I understand your findings, in about 60 percent of the cases, the vast majority of the cases, the information that they received from Medicare was either incomplete, inappropriate or inaccurate when you add all the subtotals.

Ms. ARONOVITZ. That is correct.

Mr. DOGGETT. I find that to be really troubling. You know, until some of the comments that were made here this afternoon, I thought that all of those who professed an interest in a non-partisan, objective, professional, exploration of this problem were talking about you and your study, because the GAO is that independent, nonpartisan group that does studies like this.

Yesterday, I asked Dr. McClellan about this. By the way, under your process, unlike me and the Members who requested this, Dr. McClellan has had weeks in which to respond to your study, has he not?

Ms. ARONOVITZ. Well, actually, we—

Mr. DOGGETT. He has a letter in here, in your report.

Ms. ARONOVITZ. Yes, he does have a letter. CMS was very, very good about responding very quickly. We wanted to be able to have the report ready.

Mr. DOGGETT. He has had a chance to see your findings and to react to them.

Ms. ARONOVITZ. Yes, and we did discuss them with him, yes.

Mr. DOGGETT. Okay; and he has, I think, about a 12-page response here to your report.

Ms. ARONOVITZ. That is the part we printed, yes.

Mr. DOGGETT. I guess what bothers me the most is just the total state of denial at Medicare that they have a problem. It looks to me like a 61 percent failure rate in answering the question that not some senior who is suffering from illness and some form, perhaps, of debilitation who is trying to struggle through Medicare but people who were trained to make these inquiries, they got the wrong answer the majority of the time, the vast majority of the time, and we find at Medicare and with its apologists and defend-

ers of the bureaucracy and here on the Subcommittee, an unwillingness to look at your findings, because the first way to solve this problem is a recognition that there has been a failure and then to reach out and make the changes to try to do it.

Let me ask you this: part of this state of denial that we heard yesterday was that, well, gee, a significant number of people, 87 percent, think that they are happy with the way—they are satisfied with Medicare. How does that number, which sounds so happy and so consistent with the kind of pollyannish attitude that has been brought about this legislation, how does that square with what you found? Because it seems to be just the opposite.

Ms. ARONOVITZ. Well, actually, I was very surprised at Dr. McClellan's comment yesterday that he thought that the problems that we found have been fixed. I had actually been dealing with high level officials in his agency, because they were very anxious to get the detailed results of our report. People in his office were very anxious to look at our report and try to fix things.

So, it did surprise me, to say the least, to hear him say that things were fixed. One of the criticisms that he particularly mentioned yesterday was about the question that you talk about: 60 percent could not get an answer when we called, out of 100 calls, for the lowest drug plan. Dr. McClellan said that 35 percent—the category that we call inappropriate—that we were not fair in reporting that, because when you pick up the phone and call 1-800-Medicare, the fact that the Center for Scientific Review insisted on having personal information before they would answer your phone call, Dr. McClellan said we should not hold that against the agency.

In fact, there is no difference between the information that you should be able to get through a general search—

Mr. DOGGETT. Of course.

Ms. ARONOVITZ [continuing]. Than if you were to give your personal information. The only difference, really, is that the system would know whether you had prior drug coverage or not.

So, we feel that we are trying to be objective, and we have no reason to try to do anything but use very accepted methodology.

Mr. DOGGETT. Thank you, and if there is another round of questions, I would like to hear more from you, because I think this study really tells us about the actual current state on an objective, professional basis of what is happening in Medicare, even though there seems to be a general state of denial about it.

Ms. Larkin, just in a word, does United agree with what Mr. Steinberg was saying, that it would be desirable to eliminate the assets test or significantly simplify it so we could help more of the people that rely on this low-income subsidy?

Ms. LARKIN. We are finding that seniors are struggling to complete the paperwork. We have been working with organizations like the Medicare Rights Center, who have expertise in helping people get through the paperwork. So, that is an area that we are concerned about.

Mr. DOGGETT. You would like to see the change made on the assets test.

Ms. LARKIN. Well, again, that is a decision for CMS and this body to make, but we would be willing to be helpful in that way.

Chairman JOHNSON OF CONNECTICUT. Thank you. I am sorry. The time has expired.

Mr. English.

Mr. DOGETT. Thank you.

Chairman JOHNSON OF CONNECTICUT. Mr. Hayworth.

Mr. HAYWORTH. Thank you, Madam Chairman, and again, thanks to all the witnesses.

Mr. Vaughan, I appreciated your evaluation, and visiting with my friend from Pennsylvania, that most major Government programs get off to a rocky start. I read with interest one of your comments earlier this year, quote, January is going to be very, very tough on some of the most vulnerable people in our society, you told the Nation's Health. That was your evaluation.

Now that winter has moved to spring and that events do not occur in a vacuum, have there been positive steps, or is this just uniformly a horrible situation that continues to subject seniors to tests draconian in nature to give—

Mr. VAUGHAN. No, of course not. Things do get better.

Mr. HAYWORTH. Good.

Mr. VAUGHAN. January was tough, and as Vicki and Mark are saying, there is still—

Mr. HAYWORTH. I thank you for that, and that leads to a larger question, because listening to some of the testimony today, which offered some constructive criticism and some evaluations that can only be described as shrill, let me just simply ask for a show of hands, who among you would like to see the prescription drug program under Medicare abolished?

Let the record show that not a single hand went up.

Let me also point out in closing my brief comments that while we appreciate informational hearings, we also should recognize, and indeed, we would be naive in ignoring another fact; that is, the essence of political theater. Brother Aesop offered a fable not dealing so much with a medical condition but perhaps something that is even shown in policy analysis about sour grapes.

While we hear about the inadequacies of the program and how horrible it is going to be, I dare say that it is my evaluation, both in terms of public policy and politics, that oftentimes, constructive criticism gives way to a simple matter of sour grapes, and with that culinary observation here, Madam Chairman, I will yield back my time.

Chairman JOHNSON OF CONNECTICUT. Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chairman.

Ms. Aronovitz, let me ask, I have tried to find the cut-off date for which GAO received data or at least written documents, and I think what I can find is the critique is of written documents in existence as of December 2005; is that right, or am I missing something?

Ms. ARONOVITZ. No, no, that is correct. Those are the documents that were used primarily to communicate the program.

Mr. HULSHOF. Obviously, you have to have a cut-off point at some time so you can begin to formulate the report that you have been asked to comment on, so any improvements that CMS might have made, say, for instance, in February or beyond would not have been included necessarily in this report? Is that fair?

Ms. ARONOVITZ. CMS had written and produced 70 documents by the time of December 2005, and it was really gearing up, and it had a big job. It had substantially finished its communication materials, and those were the ones that were communicated. Now, of course, they could have developed something since.

Mr. HULSHOF. All right; thank you.

I am told that reality shows are popular, and so, a couple of real world—I am told simply because, Madam Chairman, you drive such a hard-charging Committee that we do not have time to watch the networks out there. So, just really a couple of real world observations. Number one would be I guess I am the most junior Member on this Committee; in other words, the closest one to election back nine years and five months ago, and I am only thankful that I did not have someone looking over my shoulder to see my constituent mail service two months after I became a Member of this Body. Hopefully, over these nine years, things have been ironed out.

Mr. Vaughan, I reference and I applaud your testimony, the written part, that you are encouraging beneficiaries to report on their Part D experiences, good or bad, with your Share Your Story Website. Again, perhaps, a real world observation, at least from the political lens, my guess is you are going to have more negative responses than positive.

Mr. VAUGHAN. Absolutely. There are some real horror stories that hopefully we can get fixed.

Mr. HULSHOF. Because if you open up the opinion page of my hometown newspaper, there are some fairly critical observations from time to time about yours truly, and so, I always know when I am not doing a good job, because you are motivated to write. So, again, I applaud that, but the caveat I would have is that you are probably going to get mostly a negative bit.

Mr. VAUGHAN. I do think that to the extent that we finally get a scientific sample that is large enough that we can then identify X, Y, Z plans and problems that need to be fixed. The issue of people thinking they are joining a relatively cheap plan and then finding out that they were enrolled in one that is much more expensive and it is being withheld from their paychecks that I believe has been referred to the Inspector General, that may be a pattern that you ought to penalize and criminalize, because there is a bunch of that out there, I think.

Mr. HULSHOF. Thank you.

Again, just a real world observation. I think I am one of the few Members of this Committee, the full Committee, the tax-writing Committee that does my own taxes for our family and for our family business; a family friend who is an accountant his head at that very fact. Quite frankly, regarding this May 15 deadline and comparing it to the tax deadline, I cannot recall a year that I ever filed my taxes early.

So, again, we have got a few days left, and we will see how that resolves itself, but let me ask Ms. Larkin, you, specifically, since you are representing a company that is actually providing some of these plans, my colleague from Texas asked you about the assets test. Do you, on behalf of your company, have an opinion about whether that May 15 deadline should be extended?

Ms. LARKIN. No, we are going to respect the right or respect the opinion of CMS and this Congress. We are doing everything that we can to assist beneficiaries with this enrollment process. It includes things like making sure that our call centers are open 24 hours a day, that we are properly staffed, so that people who are enrolling, whether they are enrolling telephonically online or with paper application can be accommodated.

Mr. HULSHOF. My last final little real world observation. In our household, Ms. Gottlich, I have a six-year-old and a three-year-old, and every night, they are back in Missouri, and we talk on the telephone, and I ask my six-year-old, who is quite verbose, to share with me her high point of the day and low point of the day. So, as we sort of bring this hearing to a conclusion momentarily, you have shared with us some of the horror stories and negative stories. How about sharing with us a positive story.

Ms. GOTTLICH. My father-in-law took my advice, and even though he has only a \$13 generic drug payment each month, he signed up this week for the lowest cost plan in New York. Now, if you knew my father-in-law, and you knew that he does not take anybody's advice, this is really a high point in Part D.

[Laughter.]

Mr. HULSHOF. Thank you.

Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. I thank the panel.

I am going to recognize a Member of the Committee who is not a Member of the Subcommittee, Mr. Pomeroy.

Mr. POMEROY. I thank the Chair, and I am delighted to participate in this hearing.

Gosh, Congressman Hulshof, I cannot imagine where your six-year-old got that verbosity trait.

[Laughter.]

Mr. POMEROY. You know, I will give you a good, new story, too. I sat down with my 85-year-old mother, and we worked this through, and she is going to save about \$2,000 out of her \$4,000 drug bill. You sign up to this thing; most are going to save money. That is what makes the takeup rate, in my opinion, so revealing.

Paying your taxes, working on tax returns—that is a pain in the neck. If you do not get it done by the 15th, there is an extension. It is easier doing when you know you have a refund at the end of it. Well, everybody signing up, nearly everyone, is going to get a benefit under this thing. Still, the takeup rate is really quite low, about 40 percent in North Dakota, and that is better than most of the country, in part, because Republican and Democratic officials, we have worked together to try to get the word out, try to get the people signed up. I was doing an event just about a week ago with Commissioner of Insurance Jim Poolman, an elected Republican. We together want to make this work. The Governor's office has done some good work in trying to get people enrolled.

Forty percent on a program that is offering some very real benefit, in fact, a benefit that we are now finding is going to cost about double what we thought to the Treasury when we passed it, well, that tells me there is too much complexity. I think if we were running an insurance program and had takeup rates when we were trying to give away benefit, and they are not applying for it, it

would tell us, whoa, something is terribly wrong about our market interface here. We have got to have a better takeup rate than this.

So, that is what I think we need to concentrate on. Look at these macro numbers. The macro numbers tell us we have got work to do. I think we obviously want this program to work. I think there is bipartisan agreement in that one. Here we are, days before the 15th; we have got these low sign-up rates.

It would seem to me that we ought to conclude a couple of things: the program is too complex; we need to make it simpler, and in light of the complexity, which has obviously played a huge role in suppressing the takeup rate, the rate at which seniors are applying for this, we ought to give them an extension. It is the cleanest, easiest thing to do. Some are suggesting keep the May 15 date but drop the penalty. My opinion, that just adds to this confusion, and by golly, there is plenty of confusion out there already.

My own view, and I have spent quite a bit of time on this thing, is we ought to extend that May 15 date. I think people are going to—once they get through the signup, they are going to like this program.

Now, Ms. Larkin, I have got a question for you, because what we learned about the bill and implementation, we realized that there were some things that frankly reflected, I think, bad judgment. I think it was bad judgment of Congress to pass a law that—by the way, I voted for; unique to the minority, I voted for this thing—but I did not quite understand how this Medicaid dual eligible enrollment was going to work and that people would be randomly assigned to plans whether it covered the prescriptions they were on or not, and I am wondering what you did with your company when you find somebody automatically enrolled in something that no longer covers what they need.

Ms. LARKIN. Well, one of the things that we have been doing with the dual eligibles in particular is meeting with them to understand they understand the new drug benefit, and communities and States like Florida, New York, Illinois, we have actually been sitting down with dual eligibles, having Town Hall meetings and making sure they understand how to use the new benefit. We have partnered with pharmacies so that when dual eligibles come into the pharmacy, they can help understand how the drug benefit works.

Mr. POMEROY. Is there anything that you do for those that you find have been kind of randomly enrolled in one of your low-end plans that does not cover the drugs that they have been taking for years and have been paid for under Medicaid for years?

Ms. LARKIN. Well, our plans, we have a standard benefit, but the dual eligibles do have the option of changing plans. They do have that opportunity.

Mr. POMEROY. Right, and does your information outreach advise them of that, if they need something covered that the plan that they have been randomly assigned to does not cover it?

Ms. LARKIN. We try to make sure that they understand what is covered with our plan, how to use the new benefit and how to, at the pharmacy level, how to also use the benefit. They are informed of the—

Mr. POMEROY. We should never have passed something that is sticking people—known, identified individuals with known, identified prescriptions, because we have all that in the Medicaid program, sticking them into programs that do not cover what they are taking. That was just, in my opinion, done.

You know, I appreciate very much the efforts that the State Government in North Dakota, working with the nursing homes, working with others to try to make sure that people won't find themselves no longer covered get into a program that covers what they are doing, and I think this is a glitch that we all need to work on.

I would encourage all providers that are finding, those that have got coverage by virtue of being dual eligibles, but the coverage that they have got is not responding to their need, very specific feedback in terms of how they might move and get into something that covers their need.

Madam Chairman, I thank you for allowing me to ask that question of this panel, and thank you for—

Chairman JOHNSON OF CONNECTICUT. Thank you. I also will give the Gentleman from North Dakota a letter that is more detailed on these issues from Dr. McClellan, and I urge you to have a briefing from CMS on this. You get a glimpse of it through Ms. Larkin, but first of all, yesterday, Dr. McClellan did go into it in some detail, although it is much more interesting when you have the one-on-one situation of the computer interface issues and the transmission, the transfer of information issues, the problems they had between the State banks and the Federal banks and the private sector banks and how much of that they have worked out.

When we look at what works and what does not work, we may have to have a delay between the time you enroll and the time your benefit starts, because some States sort of enrolled people, and then, one State dumped 40,000, changed 40,000 from one plan to another on December 30th. Well, of course, by January 1, they were not in the pharmacy's bank.

So, there are problems that we now know and that do have to be worked out and may require changes in the law as well as procedures. How much of that they will be able to change through Executive Branch authority and what they will need to change with us, this is one reason we need to observe the deadline May 15. We need for these plans to operate, and we need to see how, then, of the slower pace of entering all those low-income people who now have no deadline, whether or not we have got the problem straightened out or not.

So, we will need to watch what we learn after May 15, when the low-income people can continue to be brought into this system and look at yesterday, I do not remember whether it was during the hearing or before, the representative of the Social Security Administration went through how they deem asset compliance. Actually, she seemed very satisfied. So, today, we get a little different view.

Those kinds of things, we will have to look at, because we do not want to ever go through again what we went through in January, February, and March. The other thing that is impressive is that for the first time, people in Meals on Wheels—the outreach was extraordinary. We have never accomplished that before, and if we had not had trouble with the people in our own State computers,

I think we could have concentrated on those who were not in the State Medicaid or dual eligible programs and been able to do a better job on the ones just outside of that box who are harder to reach, because they do not qualify for most of our subsidy programs out there. Most of them do not qualify for Food Stamps or fuel assistance. They are just above that level, and they are fairly isolated seniors.

So, that is why reaching out to family members was so important. This deadline, you are seeing a lot of people; I am seeing people walking up to me saying gee, I did not know my mother was on so many drugs. I am amused to hear my colleagues talk about their family members. I had to do it for my own sister. Somehow, she takes some pretty expensive drugs on a pretty limited income. So, we do have to help one another. There is no question about it, and we do have to make sure that the system is—the problems are solved so that November 15, they do not start again, and January 1, they do not start again. There are problems with pharmacists that we also have to look at, and we have gotten some very good suggestions from some of you today, and we thank you for being here.

I will conclude the hearing and thank you.

[Whereupon, at 4:55 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Alamosa Dialysis Center
Alamosa, Colorado 81101
April 29, 2006

To the Committee;

For the past three and a half years, I have been the social worker for the only dialysis unit in the San Luis Valley of south central Colorado. I have assisted all of our forty patients in enrolling in Medicare Part D prescription drug plans.

Almost all of these patients were already receiving good prescription drug coverage through Medicaid.

Now, however, they are facing **multiple problems** including plans not covering their medications; physicians too busy to help them with their appeals to the drug plans; pharmacists on TOTAL OVERLOAD trying to deal with these changes; and (worst of all) the prospect of the “doughnut hole,” when they all will have to pay out-of-pocket for all their medications after they reach the designated dollar amount of coverage.

Not one of my patients was afforded thirty days’ worth of a medication they had already been taking but which was no longer covered. In fact, almost all of the pharmacists, and plans, DENIED that they were obligated to provide this. **These are poor, elderly people for whom this change was devastating.**

Here in the San Luis Valley, the bright idea Congress had of **online** “shopping” for, and enrollment in, a Medicare Part D drug plan is considered laughable. NONE, not one, of my forty elderly patients has experience with, or interest in, using the internet. NONE HAS A COMPUTER. Many have bad eyesight.

Everybody knows that the elderly are **the least likely** subsection of our population for doing anything online. WHO THOUGHT THEY COULD ENROLL ONLINE???? What a stupid idea. Without my help, most of them would have done nothing. My patients only have a social worker (me) because they are on dialysis. What did other elderly do? They had no idea how to pick or join a drug plan, and so got assigned to a drug plan which probably did not cover their meds.

The architects of this MISGUIDED AND DEVASTATING CHANGE obviously had no meaningful contact with low-income elderly people. Why not?? The bene-

ficiaries of this horrid new system are the insurance companies. NOT the elderly. **Medicare Part D is shameful.**

Fran Koski, MSW, LCSW
Licensed Clinical Social Worker

Statement of the American College of Physicians

The American College of Physicians (ACP)—representing 119,000 physicians of internal medicine and medical students—is the largest physician specialty organization in the United States. Our members provide medical care to the majority of Medicare beneficiaries and the College has advocated for many years for the addition of prescription drugs to the Medicare benefit. The passage by Congress of the Medicare Modernization Act of 2003, which added prescription drugs to Medicare through a Part D benefit, and the implementation of the Part D benefit by the Centers for Medicare and Medicaid Services (CMS) in January of this year have gone a long way to bring affordable life-improving and life-saving prescription drugs to the aged and disabled members of our society. The College believes that this expanded benefit will have a significant positive effect on the long-term healthcare of the nation.

The College recognizes that the implementation of a program of this dimension, perhaps the most significant change in Medicare since its inception in 1965, would reasonably experience some glitches and “growing pains.” CMS has done a commendable job addressing a number of the early problems, which included:

- Many beneficiaries having difficulty making use of CMS informational resources—addressed by increasing the number of operators on 1-800-Medicare, making user-friendly modifications to the www.medicare.gov website and providing increased funding to the State Health Insurance Programs (SHIPs).
- Many dual eligibles finding that they were not successfully auto-enrolled in a Part D plan—addressed by establishing a pharmacy point-of-service eligibility and enrollment procedure.
- Many beneficiaries finding that their current medications were not in their Part D plan formulary and not having enough time to either have their physician prescribe a therapeutically equivalent drug or request an exception—addressed by temporarily expanding the transition period from 30 to 90 days.
- Many states having to continue to provide their dual eligible beneficiaries with medications after Part D program implementation due to the problems these beneficiaries were encountering—addressed by establishing procedures to ensure that CMS reimburses these states for their accrued expenses.

However, through this statement, the College wants to inform the Subcommittee of several continuing problematic features of the Part D program that need to be addressed by CMS and may require some assistance from Congress. The College makes the following specific requests:

- The College recommends that CMS use the full extent of its contractual authority to ensure the use of a standardized exceptions/appeals (coverage determination) request form by all drug plans participating in the Part D program.
- The College recommends that additional fair and effective guidelines regarding the use of drug plan utilization management tools be developed and implemented. It is further recommended that these guidelines be developed by a panel of stakeholders, including representatives of the physician organizations, pharmacists, drug plans and patient advocates.
- The College recommends that both Congress and CMS consider extending the enrollment deadline for the Medicare Part D benefit if there remain a large number of un-enrolled beneficiaries after May 15, 2006.

The fact that as of the end of April over 27 million beneficiaries are directly benefiting from the prescription drug program—with 8 million having voluntarily enrolled in a Part D plan and another approximately 9 million having at least creditable coverage—reflects positively on the program and its implementation. Nonetheless, there remain aspects of the program that are problematic to the physicians that must prescribe these medications and to their patients. The College strongly recommends that the Subcommittee urge CMS to address the following issues:

- The need for increased standardization in the exceptions/appeals processes employed by the drug plans.

The average physician has anywhere from 10–20 organizations providing prescription drug plans to their patients. Each organization requires different information to be supplied and different forms to be completed by the physician as part of their exceptions/appeals process. The expectation for physicians and their staff to respond differently to each of the organizations is unreasonable. It places an excessive, unnecessary burden on the practices, and provides an inappropriate incentive to avoid filing such exceptions/appeals.

Recently, an American Medical Association (AMA) work group, which included ACP, other provider organizations and patient advocate group representatives, and representatives of the healthcare insurance industry, developed a standardized exceptions/appeals (coverage determination) form that can be used for all covered Part D drugs except biotech and other high-cost specialty drugs. Acceptance of this form by all drug plans would significantly improve this situation. While CMS has designated this form as a “best practice,” the **College recommends that CMS use the full extent of its contractual authority to ensure the use of the standardized exceptions/appeals (coverage determination) request form by all drug plans participating in the Part D program.**

- There is a need to establish additional guidelines that limit the inappropriate use of drug plan utilization management tools (e.g. prior authorization, step therapy, quantity limits).

The experience of our members during the first four months of the Medicare Part D implementation is that these drug utilization management tools are being excessively utilized. Members are complaining of having to process multiple prior authorizations or step therapy requests each day. At a minimum, the large number of Medicare beneficiaries now covered under the Part D benefit radically increases physician exposure to these drug utilization management procedures. Furthermore, our members have the impression that the Part D plans are employing these cost-containing techniques at a much higher level than had previously been used in the commercial market.

The use of these tools results in increased physician workload through requiring the physician to engage in lengthy phone calls with the Part D plan or to complete various forms. The effects of these additional hurdles also cause dangerous delays in patients getting needed medications and they take clinical time away from other patients. Finally, these procedures provide an inappropriate incentive for physicians not to prescribe the drugs requiring these additional procedures.

While CMS has already developed a set of guidelines for the use of these utilization management tools, the College believes that the current guidelines are not sufficient. **The College recommends that additional fair and effective guidelines regarding the use of drug plan utilization management tools be developed and implemented that ensure the accessibility to beneficiaries of medically necessary medications, that are respectful of the needs of the providers, and are responsive to the cost efficiency considerations of the plans. It is further recommended that these guidelines be developed by a panel of stakeholders, including representatives of physician organizations, pharmacists, drug plans and patient advocates.**

- The possible need to extend the Medicare Part D enrollment date past the current May 15, 2006 deadline.

The College believes that Congress and CMS need to seriously consider extending the Medicare Part D enrollment date past the current May 15, 2006 deadline. This issue potentially could have a profound affect on the ability of large numbers of beneficiaries to enroll and take advantage of the new prescription drug benefit. Congress and CMS must maintain focus on the best interests of the beneficiaries.

Despite the large number of Medicare beneficiaries that are currently taking advantage of the Part D benefit, there remain over 7 million beneficiaries (as of the end of April) without creditable coverage who have not yet enrolled. While some portion of this group may still enroll prior to the May 15 deadline, there may remain a large number of the elderly or disabled who do not enroll in a timely manner—and will thus incur a significant financial penalty if they choose to enroll in the future. This penalty may make it prohibitive for them to enroll in the program in the future. Our members report that a large number of these current non-enrollees remain confused about the Part D plan—it is extremely complex and their lack of understanding makes them fearful of making a poor drug plan choice. This observation is confirmed by a recent Kaiser Family Foundation poll that found that one of the

most frequent reasons provided by beneficiaries without current drug coverage for not enrolling in a plan is it is “too complicated.”¹ **The College requests that both Congress and CMS consider extending the enrollment deadline for the Medicare Part D benefit if there remain a large number of un-enrolled beneficiaries after the May 15, 2006 deadline.** This extra time could allow additional beneficiaries to consult available informational resources, further discuss the issue with their physicians and loved ones, and work through their problems with understanding the new benefit. Providing time to allay beneficiaries’ confusion and fear is a good reason to eliminate this barrier to improved availability of these important medications.

The American College of Physicians is pleased that the Health Subcommittee is reviewing the implementation of the Medicare Part D prescription drug benefit. The addition of prescription medicine to the Medicare benefit is long overdue, and the College intends to continue to work with Congress and CMS to ensure the effective implementation of this very important program.

**Statement of the American Medical Directors Association,
Columbia, Maryland**

The American Medical Directors Association (AMDA) represents more than 7,000 medical directors, attending physicians, and others who practice in nursing facilities. On average, AMDA physicians see 100 nursing facility patients per month (which constituted approximately 8.5 million visits in 2000, or 42 percent of the total number of nursing facility visits that year). AMDA physicians also care for patients in other venues in the long term care continuum, which includes home health care, assisted living settings, hospice and other sites of care for the frail elderly. The majority of members (59 percent) also maintain a private practice outside of their long term care responsibilities. Our comments reflect that experience, as well as the commitment to provide the best quality of care to our patients.

Since Part D implementation on January 1, AMDA has been relaying member problems and concerns regarding the new Part D drug benefit to the Centers for Medicare and Medicaid Services (CMS) in weekly conference calls and frequent e-mails. Despite CMS efforts, we are still seeing significant problems for physicians in obtaining medically necessary drugs for their patients.

Time is a critical issue for our physicians. Over 38 percent of AMDA members who responded to a recent survey report spending 4–7 uncompensated hours per week trying to get appropriate medications for their patients under Part D.¹ Nearly 13 percent reported spending 8 or more hours per week. That is time spent largely taking care of paper, rather than taking care of patients. Requirements for prior authorizations are of particular concern, with 70 percent of respondents reporting frequent or very frequent problems. Exceptions requests also present problems, with 55 percent reporting frequent or very frequent difficulties.

Many physicians are having problems accessing particular drugs or types of drugs, with 23 percent citing problems obtaining drugs to treat Alzheimer’s disease. Some drug plans require prior authorizations for all drugs to treat dementia, a disease which affects 40 percent of all nursing facility residents. A member from Maine told us, “The hurdles created are resulting in a lower level of care being provided for nursing home patients. They are now less likely to be prescribed uncovered medication even if the alternative is inappropriate because it takes too much time and effort for everyone involved.”

The problems are exacerbated by the myriad drug plans and drug plan options with which physicians must deal. Each drug plan maintains its own formulary, policies and procedures, with no uniformity among them. Our members have seen light use of the standard form that CMS has requested drug plans to use. Only 16 percent of respondents indicate that the majority of drug plans with which they work are using the standard form.

Recurrent problems our members report include:

Lack of Critical Information about the Drug Plan

- The drug plans have often not made available correct information regarding contacts and policies, despite CMS requests since January to do so.

¹ Kaiser Family Foundation. Kaiser Health Poll Report Survey: Seniors’ Early Experience with the Medicare Prescription Benefit. April 2006. Available at www.kff.org.

¹ Preliminary results of May, 2006, survey.

- Drug plans have not provided clear information regarding procedures for exceptions and appeals, as well as prior authorizations. Likewise, there is a lack of access to drug plan forms that physicians must complete for exceptions and appeals, as well as for prior authorizations.
- Each plan develops its own procedures and forms. Although CMS is promoting use of a standard coverage determination process, its use is not mandated.
- Apparently most drug plans do not provide information on formulary alternatives when they deny coverage of a drug. The physician is often hard-pressed to discover what alternatives may be substituted.
- Our members continue to report lengthy delays in telephone access; frequent problems getting through to plans at all (e.g., busy signals, referred to other numbers; long waits). We receive frequent reports of delays of 30 to 45 minutes, after which the call is simply terminated by the drug plan.

Lack of Access for Emergency Medications

- In at least some instances, drug plans have not been available on a 24-hour basis for coverage determinations on emergency medications. In such cases, CMS is advising physicians and pharmacists to rely on the 1-800-Medicare number for emergency access, but problems have been reported with that system as well.
- We received reports of lack of access to influenza medications that may be required on an emergency basis to prevent influenza outbreak in long term care facilities. The Centers for Disease Control have approved antivirals oseltamivir (TamiFlu) and zanamivir (Relenza) to treat influenza this year. Some physicians report having difficulty obtaining oseltamivir because it is not on some plan formularies, while drugs that are on formularies to treat influenza are contraindicated for patients with seizures or Alzheimer's disease.
- We also received reports of drug plans that require prior authorization for all drugs to treat influenza. This is a special problem in long term care, where prompt treatment and prophylaxis is crucial to prevent an influenza outbreak.
- In other instances, drug plans authorized appropriate drugs but with quantity limits that were sub-therapeutic.

Onerous Administrative Requirements

Members are reporting a wide array of requirements imposed on physicians by Part D plans in order to have prescriptions honored. Many requirements entail personal contact by the physician with the drug plan, or access to the enrollee's health record, which is often not accessible to the physician, as it remains at the long term care facility. Drug plan communications with the physician sometimes leave the nursing facility completely out of the loop. Some requirements seem designed simply to deter physicians from requesting prior approvals or exceptions. For example, one physician last week reported that her nursing facility worked with the drug plan for more than four hours and still could not obtain the drug the patient needed.

As noted above, prior authorizations present serious challenges for long term care physicians. Prior authorizations are extra hurdles that physicians must jump in order to access drugs that are on a drug plan's formulary.

One member noted, "I am spending a lot of time on prior authorizations, sometimes 14 a day, and some alternative drugs are the cheap ones which cause harm. I have had patients on some of these drugs for years and have already tried the viable alternatives." Another told us, "Many patients are being forced to change their medications, even after years of success." And another physician reports that "Almost anything non-generic has become a problem."

Specific problems our members have encountered include but are not limited to:

- Requiring personal telephone calls from physicians by some plans, rather than accepting faxes or e-mails for prior authorizations or exceptions requests. This is a major problem that consumes significant amounts of the long term care physicians' time and delays access to medications. The problem is exacerbated by the fact that patients' medical records remain in the nursing facility and may not be available to the physician when he or she finally gets through to the drug plan.
- Requiring prior authorization for all drugs in a class (e.g., drugs to treat Alzheimer's disease and influenza).

- Requiring additional documentation as part of prior authorization (e.g., requiring a mini-mental status score for drugs for Alzheimer's, even of patients who are too ill to take such an exam).
- Requiring prior authorizations for inexpensive drugs.
- Requiring physicians to complete a form in order to obtain the correct form to complete for prior authorizations or exceptions.

Additional problems:

Some additional problems include:

- Lack of recommendations by the drug plan for alternative drugs when a prescribed drug is not on the formulary. Physicians often do not have access to patient records or drug plan formularies when they are called regarding adverse coverage determinations, and the suggestion of appropriate alternative drugs that are on formularies could expedite the prescribing process.
- Omission of all forms and doses of formulary drugs from drug plan formularies. Long term care patients may require alternative strength doses or alternative delivery system (liquid, sustained release, intravenous, etc.) for medical reasons, such as no longer being able to chew or swallow, but physicians are sometimes required to pursue exceptions for such different forms and dosages of drugs that are on the plan formulary.

There seems to be little understanding on the part of drug plans of the requirements regarding unnecessary drugs contained in the CMS Conditions of Participation for nursing facilities (42 CFR 483.25(1)(1), 483.25(1)(2)(i)), or of the extensive related guidance to surveyors regarding unnecessary drugs and drugs whose use may be contraindicated in elderly patients. That federal guidance, contained in CMS' State Operations Manual, recognizes that some drugs are simply inappropriate for use in frail elderly patients. We have heard of numerous incidents in which drug plans formulary drugs are medications that are considered potentially harmful in the elderly.

Finally, we are extremely concerned with the incredible burdens the new drug benefit is imposing on physicians. Physicians are reporting spending up to an hour trying to obtain just one drug for just one of their patients. Sometimes it seems that if physicians pursue problems high enough up the drug plan chain of command, problems are resolved, but our current system for providing and paying for care does not support that level of physician involvement.

In at least one instance when a physician could not obtain emergency authorization for drugs to treat an outbreak of influenza in a nursing facility and prevent the transmission to other patients, the physician had to argue for one day and discuss his willingness to speak to the press about the need to obtain the medications to prevent patient deaths in order to obtain the necessary drugs. Physicians simply should not have to go to such lengths to obtain medically necessary medications for their patients. Nor do Medicare physician payments encompass such an increased amount of work.

Right now, our members are taking on the drug plans to fight for the medicines they believe their patients need. But the current level of effort of 4 or more extra hours per week is not likely to be sustainable. The result may be that physicians have to defer to the drug plan formulary choice, regardless of whether it is the best drug for their patient.

In one such case, a physician was unable to convince the drug plan to approve his choice of antibiotic for some of his patients, arguing that the formulary alternatives would not adequately treat the patients' infection. The patients grew sicker on the drug plan's choice of antibiotics and required hospitalization for pneumonia. One nursing facility reported that some patients went without their medications for days. It seems that the pharmacy did not refill the prescriptions because prior authorizations were needed, but no one had told either the attending physician or the nursing facility.

We are extremely concerned that the impediments to medically appropriate medication that many of our members are now experiencing will result in increased adverse drug interactions in our frail, elderly patients, as well as increase reactions between drugs and patients' other medical problems. We ask for your assistance in preventing more of these situations.

AMDA Recommendations

Congress should consider how to reshape the Medicare drug benefit to simplify the program for Medicare beneficiaries and for administration. Simplifica-

tion could make the program more attractive to beneficiaries, ease the administrative burden on physicians and health care providers, and reduce the cost of the program.

In the meanwhile, several steps could be taken that would immediately improve implementation of the drug benefit, including:

- Legislation should require CMS to mandate drug plan use of one uniform procedure and form for exceptions, prior authorizations and appeals. This step is urgently needed to reduce inordinate amount of time physicians are spending trying to deal with myriad drug plan procedures and forms. As one member told us, “It is incumbent on the Medicare program to develop universal minimum standards and hold the providers to them”. The current system of voluntary compliance simply is not working.
- Legislation should specify that CMS will provide clinical direction and clarifications as needed to drug plans to ensure prompt access to medically necessary medications. Clinical directions should include, among others:
 - Requiring drug plans to include on their formularies, without prior authorization or quantity limits, drugs that CDC recommends to treat influenza each year;
 - Requiring drug plans to provide formulary alternatives, without prior authorization requirements, for formulary drugs that are considered inappropriate for use in the elderly, particularly those listed as inappropriate in CMS guidance to long term care surveyors.
 - Prohibiting prior authorization requirements for all drugs in a class;
 - Requiring drug plans to offer medications alternatives when they refuse to cover a drug;
 - Requiring prior authorizations to be provided for one year, with timely renewal notices to physicians and nursing facilities;
 - Prohibiting inappropriate and onerous requirements for drug utilization programs (such as prior authorization for inexpensive, safe, common medications, requiring prior authorizations for all drugs to treat Alzheimer’s disease, and requiring completion of one form in order to receive a second form which must be completed for drug plans to decide whether to cover medications).
- Congress should require greater CMS oversight of drug plans with quarterly public reports, and prompt application of sanctions against non-compliant drug plans.
- Congress should amend the Medicare drug benefit to eliminate co-payments for all dual-eligible beneficiaries who receive long term care services. Currently, nursing facility residents are not required to make Part D co-payments, because they pay all but a small portion of their incomes to the institution that is caring for them. But dual-eligibles residing in assisted living facilities, or who are enrolled in the APCE program or receiving home care community-based long term care services, are required to make co-payments, although they also must also pay most of their income to their care provider.

The Medicare Part D drug program was based on a managed care model which may work well for younger, healthier, ambulatory individuals. However Part D requires more flexibility in dealing with the needs of clinically fragile long term care patients with multiple drug therapies and multiple co-morbidities. A member told us, “Watching the process unfold for the past 5 months it is becoming clear to me that nursing home patients are simply being treated like community dwelling Medicare recipients. As a result, we are now seeing signs of a system failure and patients not getting their medications on time or not at all.”

Long term care physicians need your help in making the Medicare drug benefit work for their patients, and preserving the quality of medication therapy that they were previously receiving.

Thank you for the opportunity to share our experiences with you.



Campaign for America's Future
 Sherman Oaks, California 91423
April 30, 2006

To the Committee on Ways and Means

Dear Congressmen and women,

I am a 36 year old disabled citizen. I was run over by a car at age 7 and have lived my life in terrible pain and disability. To survive my pain I require quarterly injections into my implanted intrathecal morphine pump, plus daily doses of powerful narcotics to allow me to deal with my situation which will never improve but just get worse with age. When I received the information about Medicare Part D I was very skeptical because of the corruption I heard went on in Washington to get this bill made into law. The bribing of officials, the drug and insurance companies writing the laws, but being disabled and this being the law I had no choice but to accept it.

Living in California there are many choices. I spent weeks pouring over the programs, but almost every one had me spending over \$22,000 per year for my meds. At that rate why have insurance? My meds are Generic except for the pump medication which is simple morphine anyway. Your system is highway robbery. It is a total slap in the face of every single decent American and my true belief is that every man or woman who worked to make this a law will rot in hell for eternity. This is not a benefit but a curse. And not only is it a curse, but you will punish those who refuse to hop along and support your crimes against the elderly.

All of you in Washington must have had parents at one time, but I guess you have made enough money from your backroom deals that you do not need to worry about these things. Your health insurance is the best in the nation, so these issues mean little to you, but I can tell you one thing. Your greedy corrupt actions are turning America into a third world nation where Grandmas and Grandpas have to decide between food or medicine. When their northern and southern cousins across the border can buy the same meds for pennies on the dollar, the almighty American Congress rapes it's own.

I don't know if there is a God in Heaven or if Satan is in Hell, but by God if they do exist I know where all of you are going on account of the so called work you do in Washington.

Sick of your corrupt ways,

Cary Brief

Statement of the Center for Medicare Advocacy, Inc.

The Center for Medicare Advocacy, Inc. (the Center) submits this testimony to be included in the record of the hearing on Implementation of Medicare Part D, held before the Health Subcommittee of the Committee on Ways and Means on Wednesday, May 3, 2006.

Founded in 1986, the Center is a national, non-partisan educational and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The Center's national office is in Connecticut, with offices throughout the country, including Washington, D.C. The Center represents thousands of individuals in Medicare appeals each year, responds to calls and e-mails from individuals in Connecticut as well as from all across the United States, and provides support to CHOICES, the Connecticut state health insurance program. Requests to the Center for assistance have increased exponentially with the advent of Medicare Part D.

The White House and the Centers for Medicare & Medicaid Services (CMS), in their efforts to promote Part D, proclaim that "the new drug program is working well for most seniors (sic) and pays nearly all of low-income beneficiaries' drug bills." See, e.g., "The Medicare Prescription Drug Benefit: Helping Seniors and Reducing Costs," a Fact Sheet issued by the White House on March 14, 2006.

What they do not say is that many of the beneficiaries encountering problems are dually eligible for Medicare and Medicaid (dual eligibles). The barriers to their getting drugs that were previously paid for by their Medicaid programs are not temporary glitches but result from the very design of the Part D program. The Center avers, based on our conversations with Medicare beneficiaries, their families and

their advocates, that this most vulnerable population is, as a whole, much worse off than they were before they were shifted from Medicaid to Medicare drug coverage.

Problems and recommended solutions include:

1. Dual eligibles have been randomly assigned to average-cost prescription drug plans, most of which do not cover all drugs commonly used by this population.

To ensure no gaps in coverage when dual eligibles transition from Medicaid drug coverage to Medicare drugs coverage, the Medicare Modernization Act provides for them to be randomly assigned to plans if they do not choose a plan on their own. Random assignment benefits Part D drug plans by guaranteeing them an equal portion of the enrollment of the dually-eligible population, without burdening them with too large a portion. Random assignment does not, however, benefit beneficiaries.

The Inspector General of the Department of Health and Human Services has determined that nearly one-third of dually eligible beneficiaries—a highly vulnerable population with unusually high medication needs—were assigned to drug plans that included less than 85% of the 178 most commonly used Part D drugs.¹ Some of the drugs excluded from a substantial number of plan formularies (lists of covered drugs) are drugs for high blood pressure, high cholesterol and pain relief.

Only 18% of beneficiaries were assigned to plans that covered all 178 drugs, but this does not mean that even these plans cover all drugs needed by each beneficiary—only that they cover the most commonly used drugs. Moreover, even plans that cover all drugs may have quantity limits, prior authorization and other barriers to immediate and full coverage of an individual beneficiary's prescription drug needs.

Other researchers came to similar conclusions after reviewing formularies of plans available in specific regions. For example, Jocelyn Guyer and Jeffrey S. Crowley of the Georgetown Health Policy Institute wrote a series of three policy briefs for the Connecticut Health Foundation. They found large variations in the extent to which the 44 stand-alone prescription drug plans available in Connecticut covered medications, with major and frequent shortcomings in coverage of critical drugs used by dual eligibles.²

A 33 year-old beneficiary from Orange Part, Florida, described the difficulties experienced by dual eligibles in an e-mail sent to the Center last week:³

I have been on Medicaid since 1996, and Medicare since 1998. I get Social Security Disability, and I am below the poverty level. Since Medicare Part D., has kicked in. I have had to pay for medicines that Medicaid used to pay for, now I'm responsible for the co-pays of my medicines. I am a kidney transplant patient and have been a diabetic for 30 years. I also have been diagnosed with HIV in 2001. I can't pay for my medicine copays, because I make approximately \$8,500 a year. Even with the "extra help" that I get from Medicaid, I still have to pay about \$40 a month for medicines. However, my medical insurance doesn't cover my transplant medications or my HIV medications. These medicines cost about \$400, a month. What has the president done? Is there a plan to kill off the elderly and sickly, or do we just have to suffer the consequences? Thank you for letting me speak my peace.

Center for Medicare Advocacy Recommendation: In assigning beneficiaries to plans they have not chosen, more attention must be given to matching individual beneficiaries' drug usage and pharmacy preferences with the formulary and pharmacy networks of individual plans.

2. Getting coverage for drugs that are not on a plan's formulary involves engaging in one of several complex processes. The frailty of this population, including a high incidence of cognitive impairments, makes navigating those processes more difficult than for other beneficiaries.

Applying for an Exception. Each plan must have a process for enrollees to ask for an exception to non-coverage, and each plan's process is different. The Center is part of a group, spearheaded by the American Medical Association (AMA) and working in conjunction with America's Health Insurance Plans (AHIP), that has developed a model exceptions request form. Although CMS has

¹ Office of Inspector General, "Dual Eligibles" Transition: Part D Formularies' Inclusion of Commonly Used Drugs," (OEI-05-06-00090 January 2006).

² The policy briefs are available at www.cthealth.org. Judith Stein, Executive Director of the Center, was a research contributor to the policy brief on Implications for dual eligibles.

³ Beneficiary comments are verbatim and may contain grammar mistakes.

posted the model form on its web site, and AHIP members may post the form on their web sites, CMS does not require the form to be used by the plans.

An exception request must include a doctor's statement that all drugs on the formulary are either less effective or harmful to the beneficiary or both. Some plans are requiring the submission of clinical notes verifying such assertions. Because each plan's process is different, physicians must deal with multiple processes to serve all their patients. Some doctors are charging for completing prior authorization and exception request forms. Dual-eligible beneficiaries who cannot pay even nominal fees for this service cannot avail themselves of the exceptions and appeals processes.

The problems that arise from trying to navigate the exceptions process are almost too numerous to include in testimony. The issues brought to our attention by Medicare beneficiaries, their families, and their advocates include:

- Not knowing that there is a process to request an exception or coverage determination;
- Not getting through to customer service offices;
- Customer service offices not being available to accept emergency calls from doctors outside of normal business hours;
- Not having the exception request treated as an exception because the beneficiary did not use the proper term;
- Having to fax or mail to a plan a preliminary request form in order to get the request form that will start the coverage determination process. Without a coverage determination a beneficiary cannot file an appeal;
- Plans not complying with statutory time frames;
- Plans not forwarding cases to the independent review entity as required when time frames are not met;
- The independent review entity failing to conduct a new, independent review of the medical evidence.

Changing prescriptions. Plans encourage enrollees to change from an uncovered drug to one on their formulary. Such a change presumes that there is a drug on the formulary that would work as well as the uncovered drug. Making such a change may involve multiple visits to a doctor's office, each of which may cost money in terms of transportation and office visit co-pays, for the doctor to first prescribe, and then monitor, use of the alternate drug. Duals often do not have the resources to pay for the transportation or the cost-sharing for such visits. Since many use clinics, they may not be able to get an appointment with a doctor before their medication runs out.

Changing to a plan that covers the drug in question. Unlike most Medicare beneficiaries, dually eligible beneficiaries are allowed to change plans whenever they want to, with their new coverage effective the month following their action to change. Changing plans, however, is difficult and not without risks. First, the number of average cost plans in each region ranges from six to eighteen and the systems available to help beneficiaries know what each plan covers require access to high speed Internet service and a printer. Few dual-eligibles use the Internet, so to make use of these decision supports, a beneficiary must generally get help from someone else. The programs that are funded to counsel beneficiaries are overwhelmed by people needing such assistance and by the many difficulties that have arisen during the first months of the program.

Moreover, processing new enrollments in a plan is complex, requiring communication between the old plan, CMS, the new plan, and another government contractor. The information takes days to weeks to run through the system; a change made toward the end of the month will not show up in the system until later the following month, making it difficult to purchase drugs in the first part of the month.

Finally, plans can change the drugs on their formularies at any time, with 60 days' notice to individuals taking the drugs in question.⁴ Even an intelligent choice of a plan covering all of a beneficiary's current drugs could be for naught, if the plan removed some or all of those drugs from its formulary two months later. An April 27, 2006 Memorandum from Abby Block of CMS to Part D Sponsors, "Formulary Changes during the Plan Year," suggests that plans continue to cover a drug for any plan enrollee who is currently taking the drug even after the plan removes the drug from its formulary for other enrollees. Unfortunately, this CMS Memorandum to exempt current enrollees from formulary changes involving their current drugs is *not* binding on any plans. This Memorandum, like

⁴Note that the regulations specifically allow Part D plans to change their formularies. 42 C.F.R. § 423.120(b)(5),(6).

the rest of the policy guidance issued by CMS to implement much of Part D, has not gone through the Administrative Procedure Act notice and comment rule-making process, and does not have the same legal effect as the statute and the implementing regulations.

The consequences to beneficiaries are enormous, as these client experiences demonstrate.

It was extremely stressful to get a plan picked out that would even cover my medicines, I'm disabled not old and every step of the way has been a battle. The insurance company STINKS. I have to fight for nearly every prescription. From getting the right generic to one they prefer. It's almost like they are my Dr, not the insurance plan. I have had to go the the ER several times becuae I was forced to wait or fight for meds that would have helped. I also have athsma and now they are denying my singulair, suddenly some crap about needing pre-approval. This is some of the worst insurance ever. Medicare Part D is one of the worst things the Bush administration has done.

—E-mail dated April 26, 2006, from a 35 year old female in Hawley, Minnesota.

My other half has AIDS and our pharmacist suggested that we go with AETNA because it covers all his HIV meds as well as all the other meds he's on. So we signed him up for it and now it seems like each month they are not wanting to pay for certain non-HIV medications. They want him to take something else. One of those is to prevent him from getting pneumonia. It's Bactrum. Their formulary on-line says they will pay for it, but their letters keep saying they won't. After one month he's already into the catastrohic coverage part because of all the meds he's on. Every month it's a different story, a different medication is being denied. What gives them the right to play doctor with people's lives?

—E-mail dated April 26, 2006, from a 42 year old male in Land o Lakes, Florida
Center for Medicare Advocacy Recommendations:

- (1) Exceptions processes should be uniform for all plans, with a single form made available to all physicians and pharmacists;
- (2) Plans should be prohibited from removing drugs from their formulary during the plan year;
- (3) More money should be made available to programs that provide individualized assistance to beneficiaries.

3. Plans' transition policies have been difficult to get and difficult to enforce at the pharmacy level.

Each plan is required to have a transition process to address the situations of new enrollees who are taking drugs not on the plan's formulary. The transition policies include special focus on the needs of dually eligible beneficiaries. While issues with transitions have been prominent in the early months of Part D because the entire program was "transitioning" into existence, transitions will occur every month as new enrollees join plans, and especially every January, after major plan shifting has occurred during the annual enrollment period in November and December.

CMS asked plans to extend the transition coverage of non-formulary drugs through the end of March, so that beneficiaries could get a 90-day supply. Such an extension was voluntary on the plans' part. And, even after the extension request, dually-eligible and other beneficiaries are coming away from the pharmacy with no prescription, or with just a few days' supply of pills.

Moreover, the transition is merely to allow the beneficiary to change drugs, change plans, or request an exception so that her drug can be covered even though it is not on the formulary. But many beneficiaries are not receiving the notices they are supposed to get telling them what they should do next. For example, Center staff spent many hours during February and March 2006 helping a woman in California get coverage of a prescription that she had been taking for 35 years for a chronic condition. (Part of the problem was that the plan could find no record of her enrollment until mid-February.) She contacted us last week to say that, although she had received the prescription in February and March, the plan was once again telling her that the drug was not covered. We suspect that she got the drug in February and March under the transition process, and now the plan wants her to go through the exceptions process—again—to get her medically necessary drug.

A 58-year old male from Jellico, Tennessee commented to the Center via e-mail about the transition process:

I Called First Premier Health(my Provider For Part D to see if All My Medications Were Covered before I Signed on With Them, They Assured Me They Were, After 2 Month's They Wrote Me A Letter Saying that My(Pravachol) Was No Longer Covered, I Had to Try Alternative Meds First, Hell I've Tried Them All, Pravachol Works The Best For Me, I've Been On It For Over 4 Years Now!! This Does Not Make Any Sense!!! Thank You!! I Have Always been Taught When Something Works Real Well For You, Stay With It!!!!

Center for Medicare Advocacy Recommendations:

- (1) Transition policies should be uniform across plans and easily made known to beneficiaries and pharmacists;
- (2) Plan call lines, for pharmacists to get instruction to override codes, should be required to operate 24 hours a day, seven days a week;
- (3) CMS should enforce contract requirements of plans.

4. Dually eligible beneficiaries using long-term care services are treated differently depending on where they receive the services.

Dually eligible beneficiaries are provided the best Part D subsidy available under the law. They pay no premium (for an average cost plan) or deductible, have no coverage gap (doughnut hole) and no cost-sharing at all after they reach the catastrophic coverage threshold. Their co-payments vary from \$0 to \$5, depending on income or place of residence.

Dually eligible beneficiaries residing in nursing homes and certain other institutions have no co-payments, since they pay all but a very small amount of their income over to the institution that is caring for them. Dually eligible beneficiaries who are getting their long-term care services in assisted living facilities, board and care, and other similar community settings, however, are treated differently and may have co-pays as high as \$5 per prescription (for typically more than 10 prescriptions), even though they, too, must pay most of their income to their care provider and even though their care needs are similar to those of nursing home residents.

Center for Medicare Advocacy Recommendation: All dually eligible beneficiaries receiving long-term care services should be treated similarly and should have no cost-sharing obligations, since most of their income is given over to the provider of service.

5. Dually eligible beneficiaries have lost Medicaid as secondary coverage.

The most common interrelationship between Medicare and Medicaid is that Medicare is the first payer for services and Medicaid picks up where Medicare coverage stops. This is not true under Part D. Medicaid is prohibited from paying for drugs that are covered by Part D. For a state to provide the kind of “wrap around” coverage that is typical for other services, it must use its own money, without any federal contribution. According to the Inspector General of the Department of Health and Human Services, only four states have indicated they will provide some kind of coverage for drugs that are not on a Medicare plan’s formulary.

Part D imposes prescription drug co-payments for the first time on a substantial number of dual eligibles, including the 1 million dual eligibles in California (approximately one-sixth of the dual eligible population). While the co-payments for duals are supposed to be minimal, for someone living on \$817 (100% of the federal poverty level for an individual) or less each month, \$3 per prescription is a fortune. As a beneficiary from New York wrote to the Center recently, she lives on Social Security disability benefits and cannot afford to pay the \$3 co-payment every time she goes to the pharmacy.

For some dual eligibles who previously qualified for Medicaid on a “spenddown” basis, the advent of Part D means they will lose all of their supplemental health coverage. A 60-year old client from Milford, Connecticut, who has Hepatitis C, has long alternated between Medicaid and ConnPACE, the state pharmacy assistance program, to help with prescription costs during his spenddown periods. He takes several very expensive medications and qualifies for the low-income subsidy. In fact, prior to Part D, when the entire cost of his medication—including the portion paid by ConnPACE—was applied against his spenddown, he usually met his spenddown obligation in less than one month. With the advent of Part D, only that portion which he pays—his \$2 and \$5 LIS co-pays—will count against his spenddown obligation. Our client correctly perceives that he will probably never meet his \$3,000 spenddown obligation at this rate. He currently is in need of an expensive medical test that he cannot afford, and is having difficulty finding a

provider who will accept him as a patient as he no longer has Medicaid coverage and is unlikely to obtain it in the future.

Center for Medicare Advocacy Recommendation:

- (1) Amend the law to provide dual eligible coverage for prescription drugs, just as it exists for other health care services, including federal matching funds for state expenditures;
- (2) Amend the law to allow Part D drug costs, including the low-income subsidy, to count toward Medicaid eligibility based on spenddown.

6. Individuals with Medicaid will experience a gap in prescription drug coverage when they first become eligible for Medicare.

Individuals with Medicaid lose their Medicaid drug coverage on the first day of the month that they become eligible for Medicare, even if they have not enrolled in a Part D plan. The state will transmit information about them to CMS when the state becomes aware of their new dual eligibility status. It is unclear, however, whether and when states will have that information. In addition, states often send information to CMS about new dual eligibles only once a month, generally at the end of the month. CMS may not be able to enroll a new dual into an eligible plan in time for drug coverage to begin the following month. CMS has indicated that Part D coverage will be retroactive, but it is unclear how duals will pay for their prescriptions while coverage and plan enrollment is being determined.

New dually eligible individuals can use the Point of Service (POS) option at the pharmacy that facilitates enrollment into the point of service contractor. The contractor will then inform CMS so that the individuals can be enrolled into a plan. Under the POS option, the pharmacy distributes a 14-day supply of medicine to the individual, with the possibility of an additional 14-day refill. Individuals who try to get prescriptions under this option at the beginning of a month may not have sufficient medicine to last until they are enrolled in a Part D plan.

Center for Medicare Advocacy Recommendation: Identify Medicaid recipients who are about to become Medicare eligible sufficiently in advance to auto-enroll them in a Part D plan before they lose Medicaid drug coverage. Alternatively, continue Medicaid drug coverage for these individuals until they are enrolled in a Part D plan.

Conclusion

Many of the problems and issues described above arise from or are complicated by the number of plans available and the fact that each plan has its own design, including formulary, transition processes, exceptions and appeals processes. Virtually no uniformity exists or is required.

Even after beneficiaries, their families, and their advocates spend hours and days on the phone trying to resolve issues with their Part D plans and with CMS, there is still no guarantee that the problem will be resolved. Our client, Mary F., from Willimantic, Connecticut, exemplifies the problem. She gets by on limited income, and it is not unusual at the end of any month that she is down to her last \$5 in quarters for her laundry. She takes several medications, among them a pain reliever for severe gout. She is on ConnPACE and a Medicare Savings Program. She has documentation that she was awarded the full 100% low-income subsidy, and thus should be paying \$2 or \$5 for co-pays. However, Medicare has informed her plan that she qualifies for a partial subsidy, with 15% co-pays. Mary cannot afford to pay even ConnPACE's \$16.25 co-pays and, therefore, has gone without a new pain medication her physician prescribed a week ago. She is owed over \$70 in co-pay overpayments to her pharmacy and has been told it may take up to 10 weeks to be reimbursed. **Despite repeated efforts on the part of the Center, as well as CMS's intervention in this case, the problem persists.**

Overall Center for Medicare Advocacy Recommendations: Create a single, standard Medicare prescription drug benefit, administered by the Medicare program, that is uniform nationwide. Require CMS to oversee the program with mandatory due process standards.

Thank you for the opportunity to submit this written statement. We look forward to working with Congress to ensure that elders and people with disabilities have access to a meaningful and affordable Medicare prescription drug benefit.

Judith Stein
Executive Director

Patricia Nemore
Senior Policy Attorney

Vicki Gottlich
Senior Policy Attorney

Statement of Shannon Collins, San Rafael, California

I am writing to give testimony regarding my experience with Medicare Part D. I became disabled 15 years ago due to back problems. I found myself in the Medicare system at an early age, coming from excellent health insurance that was paid for by my employer. As a disabled person my Medi-gap options were severely limited. Given the few choices I had, Kaiser's Senior Advantage Plan was my best option.

Prior to the start of the Medicare Drug Plan, Kaiser already included a drug benefit as part of their Senior Advantage Plan. It has changed form during the time I've been a member, but for the past two years (2004 and 2005) the plan consisted of unlimited generic brand coverage at a cost of \$10 for a 100 day supply. (This cost was the same whether the drugs were picked up at a Kaiser pharmacy or obtained through mail order.)

With the advent of the Medicare Drug Plan my monthly membership premium increased from \$70 to \$101. The co-payments for generic drugs tripled to \$30 for a 100 day supply if picked up at the pharmacy. If obtained through mail order, the cost is \$20 for a 100-day supply—still twice as much as it cost last year.

Although brand-name coverage has been added, the copayments are quite steep—\$120 for a 100-day supply if picked up at the pharmacy, and \$80 if obtained through mail order. Unfortunately, Kaiser has also added the infamous “doughnut hole” so I am doing my best to avoid brand-name drugs because their higher price will put me on the fast track into that hole.

Diazepam is one of the generics I take. It's in a class of drugs known as the “benzodiazepines.” I've used diazepam for many years to help with muscles spasms and migraine headaches. I'm intolerant of many drugs, and this one has been a life-saver for me. Until this year I was always able to get it through the Kaiser pharmacy. However, for questionable reasons, Medicare has opted to exclude the benzodiazepines from their formulary. Rather than wade through the appeals process, I am purchasing the drug at Costco (the cheapest source I've found).

When I contacted Kaiser about my rate increases they blamed Medicare. When I contacted Medicare, they blamed Kaiser. In fact I'm not certain who is responsible; I just know I'm paying two to three times more for my prescriptions than I did last year—and I know I'm not alone. Although some people are benefitting from this plan, millions are not.

I would like to see the enrollment deadline for Part D extended through the end of this year. Then I would like to see the plan overhauled, starting with making Part D a part of traditional Medicare where drug prices are negotiated and the doughnut hole eliminated. Perhaps then, this mess that's been called a benefit, might be on it's way to truly becoming one.

Statement of Therese Emerick

Thank you for the opportunity to submit my testimony regarding the implementation of the Medicare Part D prescription drug program. I appreciate the steps that Congress and the administration has taken to ensure that people with Medicare have access to medically necessary medications, including the extension of the 2006 transition period and the special enrollment period for people who qualify for the Extra Help low-income subsidy program.

While I do not officially represent an organization, but I know that I am not alone in my sentiments or experiences. The comments below arise from my own experiences with the new Medicare prescription drug program.

At the age of nine, I began having grand mal seizures. For the next eight years, I tried numerous anti-convulsants, none of which controlled my seizures. Once, I even had a toxic reaction to a then commonly prescribed anti-convulsant. At age 17, my seizures were finally controlled by the following regimen: Dilantin Dispense as Written (DAW), Tegretol (DAW), and Phenobarbital. With these medicines, I was able to go about my life in a normal way. I graduated high school and completed my bachelor's degree from Wayne State University in Detroit, Michigan.

At age 31, I sustained a traumatic brain injury on the job leaving me unable to continue working. Shortly thereafter I was deemed eligible for Social Security Disability and Supplemental Security Income (SSD/SSI) making me eligible for Medicaid and two years later Medicare. My monthly income is approximately \$620.00 per month which includes my SSD and SSI. In addition to that, I receive approximately \$100.00 per month in food stamps, and currently hold a Section 8 housing voucher.

I am one of 6.2 million people moved overnight from Medicaid prescription drug coverage to a private Part D prescription drug plan.

Prior to January 1, I had good, affordable, reliable health insurance coverage through Medicare and Michigan Medicaid.

The Transition to Part D

In July 2005, I received a form letter from the Michigan Department of Community Health (MDCH form B 05-05) that read:

"The Federal Government is changing how your drugs will be covered. Starting January 1, 2006, Medicare will pay for your drugs instead of Medicaid. Look for information that Medicare will mail to you. Your costs will depend on which plan you are enrolled in. Later this fall Medicare will assign you to a drug plan. You can then:

"1) Stay in the plan that Medicare assigns to you; or

"2) Pick a different plan that covers your drugs.

"Help is free and a phone call away.

"The letter then referred any questions to 800 numbers to the following agencies:

"Michigan Medicare/Medicaid Assistance Program, Medicaid Beneficiary HelpLine,
1-800-MEDICARE or the Medicare Web site at www.medicare.gov."

I contacted all of the agencies listed in the letter. I looked at the Medicare Web site. I received no clear answers about how this would affect prescription coverage under Medicaid.

When I asked my caseworker, she told me that "We are still waiting for the details of how this is going to work." When I contacted my state and federal representatives and I similarly was told that the details have not been worked out.

In November, I received a letter notifying me that I was enrolled in PacifiCare's Part D plan. Per the letter's instructions, I called the plan repeatedly to determine whether or not my prescriptions would be covered, but I was unable to get through to a counselor.

When I finally did speak to a representative, I was told that I had to check my medicines on the plan's Web site. At the time, my computer was being repaired, and, access to the Internet at the public library is restricted, leaving me unable to check my medicines with those listed on my assigned plan's formulary.

Further complicating this transition, in December, I caught a virus that had the symptoms of a severe cold. Even though I was sick, I continued to call the Medicare helpline and my plan repeatedly to find out more about the Part D coverage that I was assigned to. Again, there were long hold times. In many instances, I hung up in frustration. I tried calling these help lines at different times of the day in order to reach a real person, but I was unsuccessful.

Finally, I went to the Family Independence Agency and discussed the situation with my caseworker. With her help, I reached a plan representative who explained I would be receiving a card in the mail.

I did not receive my card until the first week in January, a couple of days after I had called in my prescriptions for January. The pharmacy needed to see my membership card before they would dispense my medicines so I had to wait two days until my enrollment packet arrived in the mail. Luckily, I had stockpiled some of my medicines, so I did not have to go without.

The thought that I might have to go without my medicines was terrifying.

Currently under Part D

For now, I am receiving all of my prescriptions through my Part D plan. I pay \$8.00 in copayments every month. That amount is more than I paid prior to the transition. Previously, I paid \$1.00 per prescription. The increase in price may seem like a small amount to most. Due to the amount that I receive monthly (\$620.00 SSD/I), I have had to make hard choices including, but not limited to, paying my utilities bills late or making partial payments (resulting in my incurring repeated late charges), eating and medicine.

I will not go without the necessary medicines that is needed to control my epilepsy. The consequences of going without could invoke a condition called “status epilepticus.” Status epilepticus is non-stop seizures that require immediate hospitalization. It is often fatal.

Recent Correspondence From PacifiCare

I recently received an Explanation of Benefits (EOB) from Prescription Solutions from PacifiCare. It reads in part:

- Amount Paid For Prescriptions

“You and/or others who have paid for your prescriptions have spent \$334.47 in co-payments and/or co-insurance this year. In addition, this amount also includes any extra help that you get paying for your drugs. This amount may include payments made by your current or former employer/union, other insurance plan or policy. This counts toward your initial coverage limit.

Prescription Solutions from PacifiCare has paid \$288.67. These payments count toward your initial coverage limit.

Together \$623.04 has been paid by Prescription Solutions from PacifiCare, you and/or others. This is the total that counts toward your initial coverage limit.”

The different amounts listed cause me a great deal of concern. I have received information from multiple sources providing me conflicting information about whether or not I will fall into the donut hole—pay 100% of my prescription drug costs.

I do not understand why three different amounts are listed in the correspondence from PacifiCare. Nor do I understand other terminology that is being used in the letter and how it applies to me.

Solutions

Part D needs to be reformed so all that are eligible will receive the medically necessary prescriptions at an affordable cost.

First, an extension in the enrollment period is needed for those who are eligible. Determining which of the many plans offered best suit their needs and budget require a detailed understanding of computer/internet use, the technicalities of pharmaceuticals and the regulations on each policy. In addition, those who are eligible for Part D should not be forced into choosing a program that may not suit their needs out of the fear of increased premiums, or lack of coverage until the next enrollment period. Finally, an example of the penalty information was listed on the medicare.gov Web site as opposed to the penalty formula. (<http://www.startribune.com/484/story/400980.html>)

Second, the donut hole must be eliminated. Michael Leavitt, Secretary of Health and Human Services, gave a reason for the elimination of the donut hole. He recommended that “insurance companies to allow patients to have more than a month’s supply of prescription drugs on hand at a time, in case of emergency.”

(<http://www.casperstartribune.net/articles/2006/03/11/news/wyoming/0af12a4b085e81da8725712e000501c8.txt>)

It is impossible for those on a fixed income after they reach the donut hole, to obtain their medicines, as their prescriptions are unaffordable.

Third, the heavy reliance on “step therapies” that were described in reports by Rep. Henry Waxman should be not applicable to those who have a documented medical history in which step therapies prolonged an illness.

Fourth, the insistence on the use of generic drugs must be waived if it has previously been documented in one’s medical history that generics do not alleviate symptoms of a serious medical condition. A second reason for this is the situation that many prescription drugs do not have a generic equivalent. Yet another reason would be if a person had previous medical documentation of a sensitivity/allergic reaction to a generic drug. Extensive medical expenses can be incurred in determining if, in fact, any other type of medication/a different course of treatment would suffice.

Fifth, the appeals process needs to be streamlined and standardized, with the goal of its elimination. Many who currently have Part D have been taking the same

medications for years. Sudden changes or withdrawals from certain medications can cause serious health risks that can be fatal.

Part D must provide coverage for all necessary medications. It is not the place of any insurance carrier to second-guess medical advice. It is the function of a Part D insurance carrier to provide reliable prescription coverage at an affordable price.

According to a BBC report, dated June 27, 2003, President Bush made the following claim. "Seniors have waited too long for more choices and better benefits, including prescription drug coverage, similar to the kind now enjoyed by federal employees and members of the Congress."

(<http://news.bbc.co.uk/2/hi/americas/3026856.stm>)

Due to the five restrictions/limitations on Part D, it is not similar to the benefits and prescription coverage "now enjoyed by federal employees and members of the Congress."

Elected officials are public servants, representing their constituents. In effect, their constituents are their employers. One of the essential functions of a job description could read: to represent the will of the people in this country and to vote their concerns on issues that have a direct impact on their health and well being.

Taking that analogy a step further, it is necessary to ask a question. Why should the employee be compensated with a better health care package that is paid for, in tax dollars, by the employer, with many of the employers having substandard, if any health coverage?

The answer is that establishing a single payer health care system, including prescription, dental, and vision/optical coverage is necessary. This would result in the savings of approximately \$286 billion in paperwork alone, according to Physicians for A National Health Program (PHNP). (http://www.pnhp.org/news/2004/january/national_health_insu.php)

The ideal single payer health care system would not require prior-authorizations for prescriptions, would eliminate pre-existing conditions and/or other regulations that interfere with the best medical advice of his/her physician when determining the necessary course of treatment.

To achieve the goal of a single-payer health care system, it is necessary to recall the words of the late Walter Reuther, to the American Public Health Association, in 1968:

"We must first free ourselves of the illusion that we really have a health care system in America. What we have is a disorganized, disjointed, antiquated, obsolete non-system of health care. Consumers are being required to subsidize a non-system that fails to deal with their basic health care needs and the cost of that system is continuing to skyrocket." (<http://www.uaw.org/atissue/atstory.cfm?atId=129>)

Statement of Linda Fullerton, Social Security Disability Coalition, Rochester New York

Disabled and senior citizens definitely need a prescription drug plan under Medicare, but Part D as it is now, is a failure. Under my HMO Part D plan, I pay more now for each drug I need, than on my HMO provided drug plan before Part D took effect. My monthly HMO premium doubled, and I still have additional co-pays for each drug, with less choices. I recently got major sticker shock when I went to my pharmacy. I was told that one drug I was just prescribed would cost me over \$100 since it was not on my drug plan's formulary. I was instantly forced to make a decision that I never had to before. Do I not eat for 2 weeks, go without health insurance for two months, or do without two other medications I need for a year? Since I am on Social Security Disability, my only choice was to do without the \$100 medicine and walk out. As a result of this experience and many other horror stories that I have heard I have come to the following conclusions:

Currently disabled Americans are forced to wait 2 years to be covered under Medicare A, B, or D. That needs to change. Coverage under all parts of Medicare must start immediately for them, upon disability date of eligibility.

There should never be penalties for those who do not enroll in Medicare Part D or any other portion of the Medicare program. Medicare is supposed to be there to keep people healthy, not force them into having coverage, and penalize them into poverty for the rest of their lives, if they miss a sign up deadline. Medicare should be a healthcare program that rivals any private insurance coverage offered, and one that people would rush to sign up for on their own without the fear of penalties.

Give Americans continuous TOTAL drug coverage by removing these deductibles and gaps in coverage:

Currently you pay 25% of your yearly drug costs from \$250 to \$2,250, and your plan pays the other 75% of these costs.

Then you pay 100% of your next \$2,850 in drug costs.

Then you pay 5% of your drug costs (or a small copayment) for the rest of the calendar year after you have spent \$3,600 out-of-pocket.

These sorts of stipulations are very confusing and harmful to those who desperately need life saving prescription medicines, especially those with terminal or chronic illnesses that can least afford it.

Revise the Part D plan to allow Medicare beneficiaries to enroll in a SINGLE drug plan provided directly by Medicare so that premiums, deductibles, and co-payments, would be the same for everyone. This drug plan would be the same as the one currently in place for all other Medicare benefits. Those who want to enroll in a private plan for drug coverage could still do so, just as is allowed for other Medicare benefits. Under this proposed plan Medicare could only remove drugs after one year and must set up simplified appeals procedures so doctors/patients would always be guaranteed access to ALL medicines required to insure proper healthcare for patients.

HMO's are getting huge drug contracts under the current plan but not passing on the savings to consumers. Many are even paying more for their drugs than they were before Part D took effect when co-pays and premiums are factored in. They are also forcing their subscribers to use their Part D plans or lose their health insurance coverage in their HMO plan. This practice should be made illegal as it restricts a patient's ability to shop for the best Medicare Part D plan to suit their needs.

The current Medicare Part D plan is is an outrageous sell out (pharmaceutical payola) to the drug companies as there is no provision for Medicare to shop for the best drug prices. That needs to be changed to allow Medicare to freely shop for the most cost efficient medicines and increase the types of medicines available on the Part D formulary. Medicare must also work with the FDA to lower the amount of time that drug companies can hold patents so that more generic drugs are available in the marketplace which would lower drug prices across the board.

Congress should also pass Federal regulations (similar to those governing the tobacco industry) that prohibit the pharmaceutical companies from advertising their "prescription only" products to the general public, as this has greatly driven up the price of medicines in order to pay for these types of "commercials."

During the Medicare Part D sign up campaign there has not been enough properly trained staff to answer questions accurately or in a timely manner. Congress needs to fund this program properly so more well trained staff are put in place to handle the increased work load that the Medicare Part D implementation has imposed on the Medicare and Social Security programs. These increased staff levels must be maintained for Medicare as a whole and Social Security, even after the initial sign up deadline has passed, since the number of people eligible for these benefits is only going to increase over time as the American population ages at a faster pace compared to decades of the past.

Many disabled and elderly citizens are still having to decide whether or not to eat, pay heat/utility bills, give up other necessities in life, or go without their medicines instead. This is America, and there's no excuse for anyone in this country, to be forced into making those sorts of agonizing choices. In closing please keep in mind, as we will be sure to, that this is a crucial election year for many Congressional positions. Your ability to reform this vital healthcare program in an expedient manner, will be a very important factor in our voting decisions come November. Thank you for your time.

Sign the Social Security Disability Reform Petition—read the horror stories from all over the nation:

<http://www.petitiononline.com/SSDC/petition.html>

Social Security Disability Coalition—offering FREE knowledge and support with a focus on SSD reform:

<http://groups.msn.com/SocialSecurityDisabilityCoalition>

Please check out my website at:

<http://www.frontiernet.net/~lindaf1/bump.html>

"I am disabled and my vote counts too!"

Durham, North Carolina 27707
May 2, 2006

To the Honorable Members considering "D"

I am 69 years old, born January 26, 1937, supposedly retired, still working, even with Social Security, because I believe those who have been more blessed must help those less advantaged.

After I turned 60, like most folks, my health began to deteriorate, although it is improving since January 2005; I've lost 62 pounds on the South Beach Diet and I swim 30 laps every two days. By doing this, and thanks to daily doses of Beta Blockers, HCTZ, Lipitor, Colazol, Lisinopril, Protonix, Plavix, Aspirin, and Coreg I have been able to eliminate the Insulin, Glipizide, and Metformin I was taking for my Type II Diabetes and reduce my cardiovascular medicines by 50%, despite the fact I had a very irregular cardio rhythm in 200 that required Cardio-version, that's when they give you general anesthesia, hit you with a 100 volts stopping your heart; it took them 200 volts to start it back.

On January 1, 2006 I chose to drop the AARP J Pharmaceutical Supplement (50% Co-pay up to \$3,000) and pick up D. On March 5, 2006 I hit the "doughnut"; that day three of my drugs for 30 days cost me almost \$400.00; this month they'll cost me close to \$1,000. It turns out that the most expensive drug, Colazol, manufactured right here in the RTP by Salix Pharmaceutical costs me and medicare about \$2.00 for a 750mg capsule; the same drug, purchased by my sister, married to a British Diplomat at The Conseil d'Europe, is less than one third of a Euro, about \$0.40. Now folks, there is no reason for America to pay four times what every other country in the world pays for drugs made in our own back yard. Think about it; it is just stupid to allow this Administration not to be forced to demand equal to lowest global price purchasing.

Gentlemen, please, stop taking contributions when you run for Congress from the Pharma Lobbyists; wake up and smell the roses. Come November there will be retribution for this really unfair pharmaceutical pricing to the American elderly.

If Bush and Cheney are not working hand in glove with the petrochemical cartel to allow ridiculous pricing on imported oil there is not a cow in Texas; everyone knows his family is in partnership with the Saudi rulers and Aramco as well as with the Emir of Kuwait. If you think the dollar is in trouble now, just wait; in three months several major middle eastern producers will be demanding payment in Euros and will not accept dollars. The day that happens the dollar will exchange at about \$4000 for E100! Our purchasing power in global markets will be nil. It is really amazing how we could have again be sucked into a ground war in Asia that we can not win; we did not learn a thing from either the British or the Russians; people that don't read history, or listen to their own intelligence assets or analysts, are doomed to repeat all the old, dumb, mistakes.

By the way, if you were to slap a 10% surcharge on net taxable income above \$360,000 up to \$600,000; and a 20% surcharge on incremental earned and investment income above \$600,000, re-instate a 10% inheritance tax on estates with FMV above \$2,000,000; and increase Capital Gains taxes to 20% on assets held less than 5 years, and eliminate Social Security and Medicare Taxes, your pro-form Federal Budget for fiscal 2007, including free basic medical and Rx for all, and doubling Veterans' benefits, would go from a trillion dollar deficit to a \$500 billion dollar surplus. Do what is right and not what is politically expedient to pay off your major contributors.

Thank God and the United States Congress that this great nation requires that our Metropolitan, Regional, and Community Trauma Centers and Emergency Rooms must give free timely treatment to all sick and injured people irregardless of whether they have any money or medical insurance, but please, again, wake up and smell the roses. These City Class A Trauma and disease centers are overwhelmed. 40% of their incoming case load has zero insurance, and a large majority of the balance is either on Medicare or Medicaid.

For God's sake NOW PROPOSE AND PASS A NATIONAL FEDERAL 100% PHYSICIAN MANAGED NATIONAL HEALTH INSURANCE BASIC DIAGNOSTIC AND TREATMENT COMPREHENSIVE CARE SYSTEM. DEMAND THAT THE ADMINISTRATORS, SUPERVISORS, and AUDITORS ONLY ARE PAID 10% IN

TOTO FOR MANAGING THE PROGRAM. FUNDED IT WITH INCOME TAX ONLY. GIVE THE MONEY TO THE STATES, DISTRIBUTED BY POPULATION, STATE BUDGET INCREASE MODIFICATIONS BASED ON UNPREDICTABLE NATURAL AND CIVIL DISASTERS. PLEASE, JUST TELL THE PHARMAS THE UNITED STATES WILL ONLY BUY PHARMACEUTICALS AT THEIR LOWEST MATCHED PRICE SOLD ANYWHERE IN THE WORLD.

BAN CONFLICTED "GIFTS" TO CONGRESSIONAL LEADERS, MEMBERS, SENATORS, AND COPY THE FRENCH WHEN IT COMES TO CAMPAIGN REFORM. THE GRAFT, and PAYBACKS, SMELL!!!

Have a Great Day. Good Luck!

W.M. Harrison Jr.

Joint Statement of Health and Disability Advocates and Make Medicare Work Coalition, Chicago, Illinois

Created shortly after the passage of the Medicare Modernization Act of 2003, the Make Medicare Work Coalition ("MMW") is headed by three principal partners headquartered in the Chicagoland area: Health & Disability Advocates, AgeOptions (formerly known as the Suburban Area Agency on Aging) and the Progress Center for Independent Living. The Make Medicare Work Coalition was organized to respond to the significant challenges posed to states, Medicare consumers and health care providers by the Medicare Modernization Act of 2003. The MMW's goal is to marry public policy development with targeted education, outreach and enrollment efforts. In addition to the three principal partners, the Make Medicare Work Coalition includes over 500 service providers representing thousands of individual advocates in Illinois, all of whom have been assisting Medicare beneficiaries on a daily basis in navigating the new Part D benefit.

Together, our membership has counseled and advised hundreds of thousands of Medicare beneficiaries on Part D throughout the state of Illinois. In addition, the policy group has been involved in all major public policy issues involving implementation of Part D on a local and national level. This includes working to assure a smoother transition for dual eligibles to Medicare Part D, the continuation of Patient Assistance Programs, assisting AIDS Drug Assistance Programs nationwide in changing their programs to work with Part D, and supporting the efforts of the state of Illinois in its design of coordination and implementation of Illinois Cares Rx (the qualified State Pharmaceutical Assistance Program in Illinois) with Medicare Part D.

It is through this direct experience of working together to assist Medicare beneficiaries throughout Illinois that we submit the following observations and recommendations on improving the Medicare Part D benefit:

1. CMS should extend the May 15 deadline for enrolling in Medicare Part D. Or, in the alternative, all late penalties for the calendar year of 2006 should be waived.

The roll-out of Medicare Part D is the largest expansion of a public benefit since the 1960's. While there are strong differences of opinion on many issues regarding Medicare Part D, all agree that it is important for beneficiaries to make an informed choice about enrolling in a Medicare Part D plan. Our Coalition is working with Medicare beneficiaries everyday to assure that these informed choices are being made. But, at an average investment of 1 hour of uncompensated time per beneficiary, we are running out of time. And, we have not reached everybody.

Six and a half million of the sixteen million or 40 percent of Medicare beneficiaries who lacked prescription drug coverage prior to January 1, 2006, still have not enrolled in a prescription drug plan. Given these numbers, our job is not done. By extending the deadline, our Coalition and others like us throughout the country can reach more beneficiaries. Naturally, beneficiaries are hesitant to sign up for a benefit that is as complex as Medicare Part D is. Indeed, studies have shown that even much simpler programs, such as food stamps, are

unable to sufficiently reach all of those that are eligible.¹ We owe it to our Medicare beneficiaries to allow them more time to navigate this system. It will only lead to increased enrollment and a more robust program.

If the enrollment deadline is not extended, the late enrollment penalties should be waived the remainder of this calendar year. Seniors and individuals with disabilities should not be punished for failing to sign up for Medicare Part D this year. That is unfair. Since its roll-out, Medicare Part D has experienced many implementation problems, which is to be expected. The problems experienced by dual eligibles and others have been widely reported in the press and elsewhere, which is also to be expected. Given this environment, it is inevitable that many beneficiaries would be hesitant at this point to enroll.

The only appropriate course of action at this point is to institute a penalty grace period during this tumultuous transition. The purpose of the penalty is to encourage enrollment. This only works if individuals are aware of the penalty. Right now, we would speculate that most individuals who are not signing up for Part D don't even understand the basics of the Part D program and certainly don't understand the penalty provisions. Therefore, a lifetime penalty for failing to enroll in the midst of all of this confusion is both unduly harsh and nonsensical.

2. CMS has recently provided a Special Enrollment Period to individuals who qualify for the Low Income Subsidy after May 15, 2006. If the May 15 deadline is not extended, CMS should also provide this Special Enrollment Period to individuals who qualify for State Pharmaceutical Assistance Programs such as Illinois Cares Rx after May 15, 2006.

Recently, CMS has extended a Special Enrollment Period for individuals determined eligible for the low-income subsidy after May 15, 2006. CMS is to be commended for doing this. In effect, this allows us more time to reach the hundreds of thousands of individuals eligible for the low-income subsidy and get them enrolled into the Part D Program.

The low income subsidy is one way in which individuals with low-income can access Medicare Part D at an affordable price. In Illinois, we have a second program that assists individuals with Medicare Part D cost-sharing. It is the qualified State Pharmaceutical Assistance Program ("SPAP") called Illinois Cares Rx. Illinois Cares Rx has more generous income and no asset eligibility guidelines and, therefore, offers many more low-income seniors and individuals with disabilities affordable coverage under Part D.

Just as CMS has recognized that more time is needed to identify and enroll individuals into the low-income subsidy program and Part D, more time is also needed to identify and enroll Medicare beneficiaries who qualify for Illinois Cares Rx. In Illinois, enrollment in a Part D is not sufficient. To maximize the benefit to low-income seniors, they have to be enrolled in a plan that coordinates with the Illinois SPAP and individuals should know that their enrollment is approved before they are locked out of changing to one of these plans. CMS did this to assure that low-income Medicare beneficiaries are getting the comprehensive benefit to which they are entitled. By extending the Special Enrollment Period to those determined eligible for Illinois Cares Rx and other qualified SPAPs, CMS would be assuring that even more low-income Medicare beneficiaries are getting the most comprehensive benefit to which they are entitled.

3. Congress must address the discontinuation of the pharmaceutical company Patient Assistance Programs for Medicare beneficiaries.

"But with the disappearance of the Patient Assistance Plans, I will not be able to afford my cocktail. I will be like I was when I was diagnosed with full-blown AIDS. I will start losing weight. I will become very sick. My weight got down to less than a hundred pounds at that time. I looked like a walking corpse. . . . I will just be honest with you. I don't think Alan Greenspan or Warren Buffett could figure out how to make that \$2200 a month work with what Plan D is saying that I have to work with, and what I have to do."

James Hayes, Medicare Beneficiary and PAP enrollee

"And right now, I am depending on Patient's Assistance, which I have been told after May 15th will cease. I have received the letters from the pharmaceutical companies. . . . With high gas bills, electric bills, gasoline, and

¹Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Resources* (Washington: National Council on Aging, 2005) (citing several studies on enrollment numbers in other public programs).

just general living, you just have to make a choice. And right now, the choice is okay, but a few months down the road, it is really one that—what are you going to be able to do?”

Mr. D, Medicare Beneficiary and PAP enrollee

Prior to implementation of Medicare Part D, there was a significant population of Medicare beneficiaries that relied upon the pharmaceutical company Patient Assistance Programs. These Programs provided reduced or no cost medications to individuals who could not otherwise afford them. These Programs are a critical lifeline to many Medicare beneficiaries living with HIV, Multiple Sclerosis, cancer, mental illness, and other conditions with high drug costs.

In November 2005, the U.S. Department of Health and Human Service Office of Inspector General issued guidance that warned the pharmaceutical companies about liability arising from how their Patient Assistance Programs interact with Part D. In effect, the guidance stated that if the current Patient Assistance Programs were counted toward Medicare Part D cost sharing, this may run afoul of anti-kickback and anti-fraud laws. The guidance DID NOT forbid the Patient Assistance Programs from assisting Medicare beneficiaries altogether. It just told them that they must put certain assurances in place in future operations of their Patient Assistance Programs. Further guidance issued in April re-iterated that Programs could continue. Some pharmaceutical companies, including Abbot, Merck, Roche, and Schering-Plough have continued their Programs for at least some Medicare beneficiaries.

Unfortunately, many other pharmaceutical companies have decided to drop their Patient Assistance Programs. This will have a devastating effect on the health of individuals quoted above because Medicare Part D will not pick up the coverage in the same way nor for the same income groups that the Patient Assistance Programs did. For James, Dallas and Mr. D, Medicare Part D is unaffordable without some help from the Patient Assistance Programs. Their income is too high to qualify for Medicare Part D “extra help.” And, their drug costs under Part D are too high to be affordable. In some months throughout the year, their monthly drug bill under Medicare Part D will exceed their monthly income.

Prior to Medicare Part D, James and Mr. D were able to access their life saving medications at affordable rates. Ironically, as a direct result of Medicare Part D, they will no longer be able to afford these medications.

4. All dual eligibles should be guaranteed a drug coverage benefit that is equivalent to what is provided by Medicaid.

Dual eligibles in Illinois, and throughout the country, received a comprehensive Medicaid drug benefit prior to January 1, 2006. These populations, in general, had the most to lose from the shift to Medicare Part D and many of them are now worse off than when they were before. Many of these low income disabled and elderly individuals have now been automatically enrolled into a Medicare prescription drug plan that does not cover the medications they were on; imposes more restrictions on the dispensing of their medication than under Medicaid; and is costing them more in co-payments than they can afford.

The HHS Office of Inspector General found that many dual eligibles in every state were auto-enrolled into PDPs that covered far less than 100% of the most commonly used drugs. These formularies and benefit structures are inequitable especially as applied to populations who are least able to choose on their own.

At a minimum, dual eligibles should have a drug benefit under Medicare that is no worse than what they had under Medicaid. Congress should mandate that PDPs offer a standard dual eligible formulary and uniform benefit management tools. In addition, Congress should exempt dual eligibles from the Medicare co-payments which in many cases are significantly higher than Medicaid.

5. AIDS Drug Assistance Programs (“ADAP”) should be allowed to use funds to “wrap around” Part D and those expenditures should count toward the out of pocket expenses needed to reach catastrophic coverage.

ADAPs throughout the country have provided needed medications to individuals living with HIV since their inception. With the implementation of Medicare Part D, these Programs have been assisting the Medicare enrollees in understanding Part D and creating new program policies for interacting with Part D. ADAP Programs were given the option to cover Medicare Part D premiums, co-payments, and cost sharing. However, if ADAP does pick up these costs, none of the cost sharing can count toward reaching the Medicare Part D catastrophic

coverage. Only SPAP expenditures can count toward true out-of-pocket expenses.

Given these restrictions, the AIDS Foundation of Chicago, in collaboration with the Make Medicare Work Coalition, advocated for the passage of Illinois House Bill 4302, which is awaiting the Governor's signature. HB 4302 expands eligibility for Illinois Cares Rx, the SPAP, to include the ADAP formulary drugs. In doing this, the state can cover the cost sharing for Medicare beneficiaries and it will assist them in reaching Medicare Part D's catastrophic coverage and a more comprehensive benefit. To date, Illinois is the only state to expand its SPAP in this manner, although some other states already included HIV coverage in their original qualifying SPAP.

While Illinois has taken the lead to do this, we still strongly believe that this is not the ideal route to assist individuals living with HIV. This route requires transferring individuals to another new program, extensive education and outreach to those individuals and state agency staff, and drug coverage is spread across one federal and two state agencies rather than one agency. It also involved the time and effort to pass legislation. Ultimately, we believe it was worth it because individuals will receive a more comprehensive drug benefit under Medicare Part D by counting that assistance to reach catastrophic coverage. But, there is much simpler way to do this.

The law should be amended to allow ADAP expenditures to count toward TROOP. In this way, ADAP coverage can assist individuals in reaching catastrophic Part D coverage without having to jump through all of the hoops associated with creating or amending an SPAP. The quickest way to a point is a straight line. Here, that straight line is ADAP coverage, not the complications involved in setting up and transferring individuals to an SPAP.

6. Many of the difficulties experienced by Medicare Part D enrollees in accessing needed medications are a direct result of the Prescription Drug Plans failing to follow CMS guidance, regulations, and the MMA Act itself. Strong and swift enforcement action must be taken against the Plans to assure that CMS guidance is followed.

"I am just one person who took the time for these two people. The emergency room physicians don't have time for this. Most doctors don't have time for this. So what happens in the meantime is that patients don't get their medications. . . . We finally got to where people understand you have got to take your medicine the way we say take it or you do everybody a disservice. And now what happens? Boom. You can go to the pharmacy and leave without your medications."

Dr. O, physician, describing her ordeal with two different insurance companies

Since its inception, widespread problems have been reported in accessing medications under Part D. These problems include charging of the wrong and higher co-payments, failure to provide necessary medications during the transition period, failure to provide medications that CMS has required all plans to carry, difficulty in understanding benefit management tools or how to comply with them and many other access issues. To us, the problems have been too numerous to be considered "isolated incidents." Rather, we believe that they are evidence of a larger systematic problem with the Medicare Part D system.

To put it simply, CMS has no control over what the Prescription Drug Plans are doing because of the structure of the contractual relationships between the plans, the government and the Medicare Beneficiary. Over and over again, CMS issues guidance and it is ignored. CMS assures individuals that certain actions are not allowed, such as denial of medications in certain classes. Time and time again, denials of these medications occur. Because the contract for insurance is between the plan and the Medicare Beneficiary, CMS claims that it cannot enforce its recommendations and leaves advocates and CMS with only the ability to solve one Medicare beneficiary's problem at a time. Service providers report "fixes" in one case and then the same exact wrongful action taken against another a couple of days later.

When we discover a plan violating the law or guidance, we report the issue to CMS. CMS staff have worked with us, one person at a time, in resolving the issues. Unfortunately, rather than acting with any authority or power to compel compliance, it appears that CMS staff have the same exact difficulties in resolving a plan's violation that we do. In one case, a Coalition member worked with a CMS staff person for over a week to get a plan to recognize a beneficiary's automatic enrollment. Day after day, all this CMS staff person could do is call the plan and make a request, just as we had. The plan seemed no more inclined

to listen to the CMS staff person than it did the beneficiary or service provider. The major advantage of the CMS staff person may be a greater range of phone numbers.

With the introduction of so many plans at once, it is very difficult to assure that each individual plan is following the rules. But, CMS must. Just as CMS will enforce late enrollment penalties against beneficiaries who fail to sign up for Part D by May 15, we should expect that CMS demand compliance with its guidance, the plans and the law that created Part D. It is not enough to resolve issues one beneficiary at a time with simple requests to the plans from CMS staff to follow guidance, which has been CMS's operating mode for the first six months of this program. Not only does this require hours of advocate and CMS staff time, it provides no enforcement power in the future. Rather, CMS must come up with clearer enforcement mechanisms to implement and compel compliance with its guidance. It is not sufficient to make suggestions and hope for the best, it requires clear rule making, clear authority and clear and efficient penalties to invoke when plans do not adhere to those rules. If CMS could deal with plan violations quickly and have a retinue of compliance measures related to the response of those that violate those rules not just to one Medicare Beneficiary but over all their enrollees, it would not be long before these plan violations would decrease.

7. Congress has spent decades creating a cash assistance and health care system for people with disabilities that encourages employment. In its current form, Medicare Part D's extra help eligibility discourages people with disabilities from seeking employment and increasing their self-sufficiency.

Through the Ticket to Work and Work Incentives Improvement Act ("TWWIIA") and previous legislation, Congress, CMS, and the Social Security Administration have created an elaborate system of work incentives that encourage individuals with disabilities to gain and maintain employment. For many individuals with disabilities, loss of health care benefits is the most often cited concern about returning to work. Because of this, the TWWIIA and other legislation addressed the continuation of healthcare for individuals returning to work through extended Medicare and Medicaid eligibility and allowing states to create Medicaid Buy-In Programs.

Unfortunately, Medicare Part D's extra help program as it is currently constituted will provide a disincentive for some (many?) individuals to gain employment. Unlike other health care programs, the provisions of Medicare Part D's extra help income forces some individuals to choose between employment and health coverage. An increase in income from employment can cause someone to lose "extra help" eligibility, forcing them to use all or most of that employment income to pay Medicare Part D cost sharing. In this environment, individuals will choose to forgo employment to keep their "extra help" eligibility.

For example, Jim is a 40 year old Medicare beneficiary living with mental illness. He currently has a monthly income of \$900 from Social Security. He qualifies for Medicare Part D's full "extra help" and receives his 7 medications for \$35 per month. Prior to Part D, he received his medications from Patient Assistance Programs, with a retail value of about \$1000 per month. Jim has been seeking employment and found a job that will pay him \$1000 per month. Under current Medicare Part D "extra help" rules, if he accepts this position, he may lose his eligibility for "extra help" in January of 2007. If he loses this "extra help," his monthly medication costs plus premium under Part D may, during part of the year, be as high or higher than his earned income. Given this choice, Jim may decide not to work at all.

The current law should be amended so that Medicare Part D's extra help mirrors Public Law 99-643's two special provisions known as 1619(a) and 1619(b). Under these provisions, SSI beneficiaries who lose their SSI due to work income are still able to qualify for Medicaid until their work income meets a state specific threshold. In the same manner, individuals enrolled in "extra help" should be able to maintain that "extra help" eligibility until their earned income reaches that same threshold. By doing this, Medicare Part D will fall in line with the rest of the public benefit system that is removing barriers to employment and encouraging individuals with disabilities to gain and maintain employment.

Statement of Barbara Kennelly, National Committee to Preserve Social Security and Medicare

Madam Chairman and Members of the Subcommittee:

The National Committee to Preserve Social Security and Medicare represents 4.6 million members and supporters. Our primary mission is the preservation of these two critical programs for seniors, and support for other programs that improve our country's retirement security.

The National Committee has advocated for adding a prescription drug benefit to Medicare for many years. We agree with President Bush and Congress that modern medical practice has evolved to include a robust use of prescription drugs, which keeps seniors out of much costlier hospitals and nursing homes and results in a higher quality of life. However, while we agree with Medicare coverage of prescription drugs, we heartily disagree with the method the President chose to implement this form of modernization. After listening to our members over the years, we have concluded that the simplest and least expensive method of adding prescription drug coverage to Medicare would be to simply expand Part B to include prescription drugs—much as Medicare has been expanded over the years to cover many procedures as they were adopted into medical practice.

Since January 2004, when the Medicare Modernization Act (MMA) began to phase in, we have heard from over 650,000 of our members, who have signed over 1.8 million letters and petitions asking Congress to overhaul the legislation. They are frustrated, confused and angry about both the privatized Part D drug plan and about the impact of the MMA on the rest of the Medicare program. What they want and need is a traditional Medicare prescription drug plan which would provide them simple, cost-effective coverage and affordable drugs.

What they got instead is a privatized prescription drug plan so confusing and complex that millions of seniors have not enrolled. A prescription drug plan which actually *prohibits* Medicare from offering a drug benefit directly and negotiating for the lowest prices possible for seniors. We applaud the Administration for alleviating the most egregious effects of the "lock-in" provision by preventing drug companies from dropping or changing the cost of a drug for beneficiaries currently using the drug. However, Part D continues to lack a guaranteed benefit, and insurance companies can still drop medications seniors believed would be covered when they enrolled. They can also raise prices even though seniors are locked into the plans for an entire year. What seniors got when the Medicare Modernization Act was signed into law was a prescription drug plan designed by and for the insurance and drug industries, not this nation's seniors.

Despite how much the Administration attempts to pump up its enrollment numbers by counting millions of seniors who have not actually enrolled in Part D (e.g. those who already have better coverage from another source), or who have been automatically enrolled, the new program is clearly a case study in what can happen when a privatized program is imposed upon seniors. While this is not the bill we would have written, the National Committee has always accepted the view that some seniors would benefit from this program, despite its many flaws. For this reason, we have made intensive efforts to inform seniors of the benefit, educate them on its intricacies, and provide materials designed to guide them through the decision-making process. We have done this through repeated mailings to our members, public meetings, the creation of a *Frequently Asked Questions* booklet for distribution, and through other materials both in print and on our website. Despite these efforts, however, only about one-half of our members who have responded to our surveys are enrolling in Part D.

The reasons for this are varied. Some seniors already have better coverage through previous employers. Others are still confused about the benefit, unsure which plan best suits their needs. They are not receiving the information they need from either the plan sponsors or from CMS. The GAO report released yesterday offers a litany of enrollment problems, including long wait-times at phone centers and inaccurate information from both CMS and the plan information lines. We have heard similar horror stories from our members as well.

But a significant number of seniors have done the math and realize Part D is very expensive and inadequate. They simply cannot afford to spend the extra money it would cost them to enroll. Proponents of Part D are working particularly hard to pressure these low-utilization seniors into the program, whether or not it makes sense for them financially, because they are an essential part of the insurance risk pool.

That is clearly the primary reason the Administration has, to date, refused to extend the Part D enrollment date beyond May 15th. Millions of seniors will either be pressured into enrolling in a program that does not suit their needs or will face

late enrollment penalties for the rest of their lives, simply because proponents persist in promoting a privatized drug benefit. Instead of acknowledging that these seniors may be justified in refusing to participate in a program that is too expensive and complex, the Administration appears determined to pressure them into enrolling with the threat of lifelong penalties.

Despite how inadequate the drug benefit appears to many seniors today, this is its high water mark, because coverage will become more expensive with time. The lack of meaningful drug cost containment will allow drug prices to continue growing faster than the economy in future years. This makes it increasingly hard for seniors, many of whom rely on Social Security as their primary source of income, to keep up. According to the new 2006 Trustees Report, the national average Part D premium is expected to reach almost \$60 per month by 2015, and the prescription drug deductible will grow from \$250 to \$475 per year. In addition, CBO has estimated the \$5,100 threshold for catastrophic coverage will almost double, to over \$9,000, in seven years.

The National Committee believes these problems can be avoided by overhauling the program to allow seniors the choice of staying with traditional Medicare for their prescription drug coverage. Relying on the strength of Medicare beneficiaries' purchasing power to directly negotiate prices would keep costs low. The Federal Government has a long history of negotiating significant price discounts on prescription drugs for both veterans and Medicaid beneficiaries. One study by the Congressional Budget Office found that, on average, the Veterans Administration pays only about 42 percent of the Average Wholesale Price (AWP)—otherwise known as the suggested list price—for brand-name drugs. Similarly, the Medicaid Rebate Program negotiated by the Federal Government with drug manufacturers, pays only about 51 percent of the AWP for brand-name drugs.

Several studies have shown that private Part D plans cannot deliver the same low prices found in other federally-negotiated programs. One study by Families USA found that the VA negotiated substantially lower prices for 19 of the top 20 drugs prescribed to seniors, compared with private Part D plans. Another study by the Minority staff at the House Government Reform Committee found that the average drug prices offered by the ten leading Part D plans were 84 percent higher than federally negotiated prices (Federal Supply Schedule). A third study by the Prudential Equity Group forecasted that drug companies could receive up to \$2 billion in extra profits in 2006 alone because private Part D plans cannot match the low prices that the Medicaid program paid for prescription drugs. Based on this study, a pharmaceutical economics professor at the University of Minnesota has concluded that drug companies could stand to gain \$40 billion in extra profits over the next decade unless Medicare is permitted to negotiate lower prices just as the VA does.

But the MMA is not only a mechanism for enacting a drug program that provides considerable financial benefit to the drug and insurance industries. In passing the MMA, the President and Congressional majority used the lure of prescription drug coverage as a smokescreen for passing legislation intended to ultimately privatize all of Medicare—a goal that the debate on Social Security shows us might not have been supported by the American public had it been proposed explicitly. This was done despite the success and popularity of the traditional fee-for-service Medicare program, and despite the failure of past privatization efforts such as Medicare + Choice. Not only is the prescription drug benefit delivered only by private stand-alone prescription drug plans or private Medicare Advantage plans, but the law threatens traditional Medicare by providing numerous subsidies that favor private companies over the traditional program and by establishing a “premium support” demonstration that places the two in head-to-head competition over price in a few short years.

The subsidies built into the MMA create an uneven playing field that will siphon away healthier and wealthier beneficiaries into private plans, while our country's most vulnerable seniors—those who are among the oldest, poorest and sickest—are left in the traditional Medicare program, where costs will keep rising. Although proponents of privatization have argued that private companies can provide health services to seniors less expensively than Medicare, actual experience with private plans in Medicare has been unequivocal—*private plans do not reduce Medicare's cost, they increase it*. And these extra costs have been confirmed by the government's own estimates, as Medicare's Actuary has estimated that overpayments to private plans under the MMA would total \$46 billion in the first decade alone.

Subsidizing private plans exacerbates the fracturing of the insurance risk pool that has been essential to the success of the Medicare program. It creates a downward spiral as increased costs—including the costs of the subsidies themselves—are spread over a pool of seniors that continues to shrink as younger, healthier beneficiaries are enticed into the more profitable managed care plans. Because the sub-

sidies are mostly hidden from view, many seniors are unaware that they are helping pay for the process that is undermining the only universal, affordable health insurance they can rely upon throughout their retirement.

The National Committee strongly believes that beneficiaries who choose to remain in the traditional Medicare program should not be asked to subsidize the inflated costs of private Medicare plans, nor should they unknowingly be required to contribute to the dissolution of the Medicare program. We also strongly believe that traditional Medicare can outperform the private sector when allowed to compete on a level playing field, using the purchasing power of America's 43 million seniors to lower costs and to create broad risk pools that spread the insurance burden among all beneficiaries. Savings achieved through a strengthened traditional Medicare program should be used to reduce costs to participants or further enhance benefits.

We urge Congress to revisit the Medicare Modernization Act before this year's adjournment and implement the following four changes: modify Part D so seniors can receive their prescription drug coverage directly from Medicare and require Medicare to negotiate the lowest possible drug prices; eliminate the lifetime penalty for seniors until this confusing plan is overhauled; eliminate the "lock-in" by prohibiting insurance companies from dropping medications or raising prices while seniors are locked into their plan; and repeal the government subsidies to private plans, using the savings to improve the drug benefit for seniors.

Thank you, Madam Chairman.

Kewanee, Illinois 61443
April 25, 2006

Dear People:

I am a disabled 56 year woman who has multiple disabilities, including depression, fibromyalgia and 3 kinds of arthritis. I take drugs for ERT, Depression, Restless Leg Syndrome, constant pain, all kinds of vitamin and mineral supplements (which are not included in any reimbursement program, even though I need them medically after having had Roux-en-Y gastric bypass surgery) and ADD And, to top it all off, I have developed hypoglycemia as a direct result of the gastric bypass and must eat certain food (which do not include anything that is less expensive . . . I cannot eat rice, pasta or bread). Since I am disabled, and not yet 55, my choices for help (both for RX and medigap) are very limited to two or three companies. I have had Humana Gold, and I have one primary care (at \$20 a visit), and each specialist (6 of them) are \$35 a visit. I have been on several of the drug companies "helping hand" programs, where I got my drugs for nothing or a small fee. All of those programs have been discontinued because of Medicare D. The Humana program is covering most of the drugs for a \$5, \$30 or \$60 copay. My tests are 20% of charge copay. When I reach the 3rd tier for the drugs, it will be even more expensive. I am spending, between doctor's visits, drug copay and test co-pay, almost \$400 a month. I am between a rock and a hard place and have had to dip into my 401K and will have to pay taxes on my withdrawals next year, and have no idea where I will get that money. I also have very little 401K left, so have only about 2 more months of payments to make easily, then I will be struggling to make ends meet. As it is, I do not go out much, and when I do, my brother and sister-in-law usually pay my way, and I feel like I cannot take care of myself (and after a lifetime of not depending on anyone, it is a blow.)

So, the upshot is that this new program is unacceptable. It is confusing (to say the least) and intolerably convoluted at best. I am not sure who actually invented this program, but I am sure it was someone who was either brilliant (we are talking Einstein here) and wanted everyone else to know how brilliant, as he (or she) would be the only ones to be able to figure it out, or someone who was tied to drug companies to make it as complicated as possible, so they would end up with more money.

Because I had to wait two years for Medicare to kick in, I was in great financial straits trying to pay for all the medical needs I had, but was so relieved when Medicare kicked in. I am not so relieved anymore. "D" has made it impossible for me to continue on the free (or low cost) individual drug programs I was on. Humana has changed their formulary twice in the last 3 months, and I have to tell you, I am almost positive that once the 15th of May comes along, and we are not able to switch, the formulary on every single Medicare "D" insurer will change again. This is probably the worst system you could have implemented.

I urge you, at the very least, to please extend the May 15th deadline. I urge you to follow through and actually simplify (not complicate) the program to an extent

that everyone can understand it. I have a BS degree, and even with having a degree in BS, I cannot make out what was the ultimate goal of this program.

I am also worried about those of us who are confused or forgetful or challenged with mental illness not under control with medication. Mine is under control (at least at the moment when I can afford my meds), and I do not understand these ill-defined rules and regulations, so there is no hope for those who are the slightest bit confused.

Please, I urge you:

1. Extend the deadline for sign up to August at least.
2. Do not penalize those who have not signed up with a “forever” monetary penalty.
3. Revise this mess and make it comprehensible, and easy to interpret.

Thank you for your time. If you have any further questions or wish any further comments, please feel free to contact me below.

Alice Rose Kieft

Salt Lake City, Utah 84106
May 1, 2006

House Ways and Means Committee

I am not an enrollee in this plan. I have no immediate plans to enroll. This plan was hastily and poorly constructed along partisan lines with significant special interest pressure placed on House and Senate members by the powerful pharmaceutical industry.

The Plan is complicated and complex. All legislative members should learn a simple lesson from the computer programming industry in their very powerful and simple acronym—K.I.S.—simply translated as “Keep it Simple.” Often they add another “S” to the expression—standing for “Stupid.” Very appropriate for the outcome of this terrible piece of legislation, which ultimately hurts constituent citizens, but certainly enriches the pharmaceutical firms.

The Plan was written the way it was, I believe, to continue the pharmaceutical companies’ continued political contributions support to many if not most of the Nation’s elected representatives. This is obvious to me as there is no provision to negotiation of pricing. The pharmaceutical firms will charge what they wish. This is a major weakness which I hope will be overcome. Until it is, we will continue to see many more States taking the position of implementing their own plans, thereby weakening any centralized attempt to potentially benefit the entire citizenry of the Nation.

I resent the undue influence of special interests which predominate in all phases of the House and Senate business. It is about time that all of our elected representatives get back to the basics—governing our Nation with the interest solely being that of the Nation and its citizenry, and not their desire to be re-elected with special interest funding.

Sincerely,

George J. Mierisch

Huntington, New York 11743
April 28, 2006

Representative Nancy L. Johnson
 House Ways and Means Committee
 Health Subcommittee
 1100 Longworth House Office Building
 U.S. House of Representatives
 Washington, D.C.

Dear Representative Johnson:

I am a twenty-eight year old woman with cognitive and psychiatric disabilities living in Long Island, New York. I would like to share my experiences regarding the Medicare Part D benefit as part of the May 3, 2006 hearing. As a "dual eligible" receiving benefits from both Medicare and Medicaid, I have experienced numerous difficulties stemming from the new benefit.

I fervently wish that Part D had not come into existence. I take ten prescription medications, and was much better off when they were covered by Medicaid. During the many years when I received drug coverage through Medicaid, I fell into a special category and thus paid no copays at all. My sole sources of income are SSI and SSDI, and even the small copays required under Part D have forced me to rearrange my budget, leaving less money available for such necessities as groceries and clothing.

While I am in fact losing money under Part D, the government has arbitrarily determined that I am saving money. As "everyone" is "obviously" "benefiting," my food stamps have been reduced. The judgment that I can afford this was arbitrary. Evidently, I am being "lumped" into a category with many others, with no effort to investigate my situation. My need of a subsidy to help pay for Part D hardly implies that I need no further assistance from the government.

Since my Medicaid prescription drug coverage ended December 31, 2005, my participation in Part D was made mandatory. Were I have opted out of Part D, I would have lost my Medicaid benefits, though I was better off beforehand. How can people like me obtain independence if the option to pick and choose individually appropriate benefits is removed? The government automatically enrolls dual eligibles in a plan with a premium below their region's benchmark. A plan is randomly selected; no regard is given to the medications taken by the enrollee or the pharmacy s/he uses. Not surprisingly, the plan into which I was auto-enrolled included neither my pharmacy in its network nor covered all of my medications, so I was forced to switch. It seems to me that the government is not particularly concerned about placing dual-eligibles in plans suiting our needs. Rather than make the effort to assist people like me with appropriate placement, officials have merely ducked their responsibilities and have decided to funnel us into plans. If we are not happy with them, it is our responsibility to change, because the government has "taken the easy way out."

Meanwhile, I was making phone calls and conducting research. Even though I had automatically eliminated plans above the benchmark, I still had many others to investigate. I had a great deal of difficulty sorting out the information. The process took me three or four months due to the complexity of the situation and the problems I encountered. For instance, I found that the CMS Formulary Finder often listed a drug as covered by a plan and was thus at odds with the plan website. In other instances, there was a discrepancy between the two regarding the use of drug utilization management techniques (quantity limits, step therapy, prior authorization) for a drug. I had to create numerous charts and lists of my own in order to keep track of all the information.

Some of the plans had to be rejected because their formularies indicated that they did not cover some of my antipsychotic or antidepressant medications, even though CMS has determined that all of these medications must be covered. Other plans did cover them, but used drug utilization management techniques to manage their use. It is my understanding that plans are not permitted to apply these techniques to drugs in certain categories (including antidepressants and antipsychotics), with few exceptions. Since CMS supervises and manages Part D, it is responsible for ensuring that the plan sponsors adhere to the regulations it establishes.

Since I am eligible for a full subsidy, I called plans in order to determine my copays. Many plan websites did not include the information. Some were not even working as of November 15, the first date of enrollment. Due to a misunderstanding, I mistakenly believed that I would have different copays under different plans. Many of the people I spoke to did not know how much I would pay, or the information differed from plan to plan or even between two representatives of the

same plans. The matter was eventually clarified. Additionally, when discrepancies between the Formulary Finder and plan websites necessitated a phone call, different representatives from the same plan would supply me with different information. This is indicative of a lack of coordination between CMS and the private insurance plans, as well as among the plan employees themselves, and that is inexcusable.

Once I had selected a plan, the United Healthcare-sponsored Medicare MedAdvance, I enrolled online. Although I received a letter from the plan shortly after, I did not receive my plan identification card until midway through January 2006. No attempt was made to prioritize the applications of dual eligibles such as myself, even though the benefit started for me on January 1st, 2006, as my Medicaid drug coverage ended on December 31, 2005. In contrast, non-dual eligibles did not need to start using Part D on January 1st. It took a phone call to MedAdvance—during which I was placed on hold for forty-five minutes, though federal requirements state phone calls must be answered within a reasonable time period—to confirm that CMS had not yet finished processing my application! Fortunately, the representative eliminated a major worry by informing me that I could use the letter from the plan as proof of (pending) membership. I should not have had to go to such lengths to confirm the letter's validity just to ensure that I could obtain my medications even without my identification card.

In addition, I am frustrated about the lack of attention given by MedAdvance to maintaining its website. A newsgroup e-mail alerted me to a change in coverage regarding two prescription forms of niacin. Originally deemed ineligible for coverage because they are vitamins, CMS has changed its mind because these medications can be covered at the plan's discretion because they are used to treat high cholesterol. I should like to discuss taking one of these medications with my doctor, but I wanted to determine whether or not the plan covers them. The section of the MedAdvance website detailing formulary changes has not been updated since March 2006, while permission for coverage of the drugs was granted by CMS in April 2006. In terms of efficiency, especially considering the wait time during phone calls to MedAdvance, obtaining the information via website is usually easier than making a phone call. However, the website information is not current. Additionally, I am having some difficulty trusting the plan representatives to provide current and accurate information, given my experiences with various personnel while I was choosing a plan in which to enroll.

Based on my own experiences, I have determined that Medicare Part D is not a boon but a blight upon our country. Although I was able to research and choose a plan of my own, I experienced a great amount of difficulty while doing so, and have had further problems with the prescription drug benefit. I would like to point out that many individuals were not and are not able to research and choose plans themselves, nor to navigate the maze after enrollment. Many seniors are uninformed or lack my computer skills; dual-eligibles may often have impairments too severe to enable them to effectively advocate for themselves in this particular situation.

If the level of civilization within a society is gauged according to the treatment given its vulnerable populations—both the disabled and the elderly may be considered as such—then Part D is a mark against the United States Government and against the insurance and pharmaceutical companies of America. In the future, more attention must be paid to the individual needs of beneficiaries. Efforts should be made by both the government and the insurance and drug companies to improve communications within and between companies and the government, and with beneficiaries. The government ought to cease to dictate terms to the disabled and the elderly through regulations purporting to be in our best interests, therefore robbing us of the independence to which we are entitled.

Thank you for your time and attention.

Yours truly,

Jessica Miller

Muncie, Indiana 47304
April 27, 2006

Medicare part D's 1 percent penalty per month for late enrollment is of great concern to me. I already know and my pharmacist has confirmed; I will be throwing my money away paying premiums now to protect me in the future from the 1 percent penalty. I am not eligible for the Social Security extra help because of assets

exceeding \$11,500. Also, I am not eligible for the Medicare Hoosier RX program solely because I am under 65. More than likely there are others out there who are in the same position I am in. It is my hope that the House Ways and Means Committee will be able to do something to permanently eliminate this 1 percent penalty.

Sincerely,

Linda A. Muckway, B.S.W.

**Statement of Andrew Sperling, National Alliance on Mental Illness,
Arlington, Virginia**

Chairwoman Johnson, Representative Stark and Members of the Subcommittee, the National Alliance on Mental Illness (NAMI) thanks you for holding this important and timely hearing. As the largest national organization representing individuals with severe mental illnesses and their families, we place a high priority in full and effective implementation of the new Medicare drug benefit.

As you know, NAMI supported the Medicare Modernization Act (MMA) when it passed Congress in 2003. Through our 1,200 affiliates, we have worked hard to make sure that the program is smoothly implemented—especially for the low-income Medicare beneficiaries living with chronic illnesses—the population most in need of strong and stable prescription coverage.

Overall CMS Performance and Assistance to Vulnerable Beneficiaries

The MMA represents the most far reaching changes to the Medicare program since its inception in 1965. The Part D program alone has involved enrollment of nearly 30 million people into new coverage over a very short period of time. Without question, any effort to initiate new coverage of benefits and shift such an enormous volume of beneficiaries into new coverage (especially the 6.2 million dual eligible beneficiaries) will result in disruption in coverage and administrative problems.

From NAMI's perspective, even a single vulnerable beneficiary experiencing problems in enrollment or initial transition is a problem. At the same time, it is important to recognize the tremendous progress that has been made since January and February. The problems that were experienced by beneficiaries early in 2006—long waiting times at 1-800-MEDICARE, inability to accurately confirm plan enrollment at the pharmacy counter, frustration with transition refills, lack of compliance by drug plans with formulary coverage requirements, etc.—have improved significantly in recent months. NAMI would like to commend the hard work of senior management and the staff at CMS in effectively addressing many of these problems. The staff at CMS has been extremely accessible and responsive to NAMI and many other groups representing beneficiaries and their family members.

NAMI is concerned that the Government Accountability Office (GAO) study released earlier this week on education and outreach efforts at CMS fails to capture the improvements that have been made since January and February. For example, we understand that wait times at 1-800-MEDICARE have shrunk significantly since the time period measured in the GAO study.

Further, the GAO study appears to be overly inclusive in classifying information provided by CMS staff as inaccurate or incomplete. In fact, information provided by CMS is designed to be specific to the individual beneficiary (or their family member) that have called in—not general information about the program. CMS should be judged on how it meets the needs of actual beneficiaries with their specific needs and the GAO report appears to have missed this key performance measure.

Medicare Part D has been in effect for barely 120 days. While it is important for the GAO to continue to provide oversight and investigate the performance of CMS the private sector plans that offer drug coverage, it should be recognized that this report is only a snapshot taken in the earliest days of the program. By contrast, Part D will be with the Medicare program for many years to come. NAMI—like all other groups representing beneficiaries—are in this for the long haul.

Transition of Dual Eligibles to Part D

NAMI continues to be concerned about the performance of Part D drug plans in meeting their responsibilities with respect to “continuity of care” for dual eligibles with severe mental illness and other disabilities and chronic illnesses. By “continuity of care” NAMI is referring to the critical issue of ensuring that dual eligibles with severe mental illness do not have their ongoing care interrupted. The consequences of interrupted access to medications for duals with mental illness can be

severe. Treatment for diseases such as schizophrenia, bipolar disorder and major depression is complicated and typically involves the prescribing of multiple medications and significant co-morbidities. Lack of coverage to any medication, even for a short period of time, can have disastrous results. Further, most of the medications commonly prescribed to treat these disorders (including anti-psychotics, anti-convulsants and anti-depressants) are NOT clinically interchangeable.

CMS Formulary and Transition Guidance—Critical Protections for Dual Eligibles

NAMI has therefore been especially concerned that protections be in place on an ongoing basis to ensure that all Medicare beneficiaries with mental illness—especially dual eligibles—are able to make a smooth transition to Part D and maintain access to the specific medications prescribed to them over the long-term. In response to both of these concerns, CMS has issued guidance to all Part D plans. These include:

Transition Guidance—This guidance requires Part D plans to continue covering all medications prescribed to a beneficiary in any initial transition period. CMS has now extended this guidance for the 2007 contract year. NAMI applauds CMS for keeping this key protection in place. This will be especially important for dual eligibles who must go through random assignment to a Part D plan again in 2007.

Formulary Guidance—This requires all Part D plans to cover “all or substantially all” of the medications commonly prescribed to treat mental illness including anti-psychotics, anti-depressants and anti-convulsants. NAMI is extremely pleased that CMS has renewed this guidance for 2007. This requirement for broad formulary coverage is essential to making the benefit work for beneficiaries with severe mental illnesses.

NAMI is extremely grateful to CMS for renewing both of these guidance requirements for all PDPs and MA plans for 2007. Continuation of these protections will ensure that prescription drug coverage is effective and uninterrupted for those who need it most—Medicare beneficiaries living with chronic illnesses with complicated treatment needs and high drug costs.

Beyond the critical protections in the CMS formulary and transition guidances, NAMI is extremely concerned that some drug plans are increasingly using “safety edits” as “cost edits.” These safety edits are typically used as quantity or dosage limitations, and in some cases, to outright deny coverage. NAMI respects that drug plans need to ensure that a medication prescribed for an enrollee is clinically appropriate. At the same time, these safety edits should never be applied against a dosage or quantity of a medication (especially for an antipsychotic medication prescribed to treat schizophrenia) for which a beneficiary has previously achieved clinical stability.

Providing Additional Guidance to Allow Manufacturer Sponsored Assistance Programs to Supplement Part D

Mr. Chairman, as you know there has been a great deal of confusion around the current status of pharmacy assistance programs (PAPs) offered by drug manufacturers for low-income Medicare beneficiaries. In response Part D, some of these programs have either shut down, suspended enrollment, or plan to cease operations at the end of the Part D open enrollment period (May 15, 2006). This is situation is further complicated by confusing guidance that was put forward by the HHS Office of Inspector General (IG) in November 2005. This guidance calls into question whether PAPs can legally supplement coverage under Part D for low-income beneficiaries who do not qualify for the Part D low-income subsidy (LIS). CMS claims that these programs can offer assistance outside of Part D, yet the IG's guidance creates enormous legal and administrative barriers to the development of creative approaches that would clear the complex legal standards set forth by the IG.

This is an especially important issue in NAMI's view since there are likely millions of low-income Medicare beneficiaries who are close to (and in some cases below) the 150% of poverty upper limit for LIS eligibility who are now worse off under Part D. This is occurring because they are failing the asset test for LIS eligibility and simultaneously losing access to a manufacturer-sponsored PAP that offered them coverage for their medications at little or no cost prior to Part D.

In NAMI's view, the complex legal and administrative issues preventing this problem from being resolved must be overcome. While we respect the IG's independence, NAMI would encourage this Subcommittee to make every effort to persuade all sides involved—especially the IG—to resolve this matter as quickly as possible. This is especially urgent with the end of the open enrollment period looming just a little more than 10 weeks away. There is absolutely no reason why legal and administrative roadblocks cannot be removed so that PAPs and charitable organizations can

make assistance available to low-income beneficiaries. This should include assistance for:

1. Dual eligibles living on SSI facing a serious financial burden even with cost sharing as low as \$1 for a generic and \$3 for a brand name (many dual eligibles living in group homes or assisted living facilities have disposable income as low as \$15 to \$20 per week),
2. Low-income beneficiaries who failed to qualify for LIS solely because of assets above the limit who cannot afford monthly premiums and annual deductibles, and
3. Individuals below 200% of poverty who end up in the doughnut hole coverage gap.

In each of these cases, NAMI agrees with CMS that assistance should be linked to enrollment in a Part D plan. It is critically important that any assistance from a PAP or charitable organization not serve as an inducement to not sign up for coverage—and assessment of a late enrollment penalty in future years.

In recent weeks, a few manufacturers have received blessing from the IG to initiate PAPs that will operate independent of Part D by offering free medications to qualified individuals that have signed up for Part D coverage. This is an encouraging step forward. However, NAMI would nonetheless encourage this Subcommittee to continue to press CMS to issues such as cost sharing for dual eligibles and assistance with premiums and deductibles for beneficiaries below 150% who failed to qualify for LIS because of the restrictive asset test. Accessing free or deeply discounted medications would obviously be helpful for them, but not a substitute for the assistance they need to fully participate in Part D coverage.

Repeal of “Non-Interference” and Restricting Beneficiary Choice

There has been a great deal of discussion in Congress about repeal of the so-called “non-interference” provision in the MMA that limits the authority of the HHS Secretary to engage in direct negotiations with drug makers over cost and access. NAMI is concerned that changing this critical piece of the Medicare Part D benefit and allowing the Secretary to negotiate a single national structure for access to medications could be extremely disruptive for beneficiaries. In short, NAMI is concerned that repeal of the “non-interference” provision will inevitably lead toward these PDPs and MA plans having to follow a single national structure for access and coverage.

Further, it is NAMI understands that both the CMS Office of Actuary and the Congressional Budget Office (CBO) have concluded that repeal of the “non-interference” provision would not result in any additional savings beyond the discounts from manufacturers that the multiple private sector plans have already been able to achieve through the competitive process that CMS has put in place. Our experience with the VA, state Medicaid agencies and other public sector payors makes clear that a single governmental authority negotiating for a single price and formulary structure deals to restrictive formularies that in the end hurt the most vulnerable beneficiaries.

Congress Needs to Address Cost Sharing for Duals and Benzodiazepine Coverage

Mr. Chairman, as you know a broad range of legislation has been introduced in the House this year to address concerns with the new Medicare drug benefit. They range from proposals to completely suspend the benefit to replacing the new program with a government managed program. NAMI believes that in many cases action on legislation to completely overhaul the new benefit is premature at this point. As you know, the President has made clear that he is firmly opposed to any major structural reforms, much less the scrapping of the entire benefit.

At the same time, NAMI believes that there are several bipartisan bills that make minor adjustments to Part D that would resolve specific narrow problems with the new benefit, while still allowing CMS to proceed with the new program. Two specific bipartisan proposals that NAMI would recommend this Subcommittee give serious consideration to are proposals that would address cost sharing for certain dual eligibles and the mandatory exclusion of benzodiazepines.

- **Duals Cost Sharing (S 2234)**—The proposal, introduced by Senators Gordon Smith (R-OR) and Jeff Bingaman (D-NM), would require Medicare drug plans to waive cost sharing for dual eligibles in certain community-based residential programs such as licensed group homes and other residential treatment settings (just as the law currently requires for dual eligibles in nursing homes and psychiatric hospitals).

- **Benzodiazepine Coverage (HR 3151)**—The proposal, introduced by Representatives Ben Cardin (D–MD) and Jim Ramstad (R–MN), would repeal the current requirement for Medicare drug plans to exclude coverage of medications known as benzodiazepines (klonopin, ativan, xanax, etc.) and allow drug plans to cover them at their discretion. It should be noted that the vast majority of states are covering these medications for dual eligibles as allowed by CMS.

NAMI strongly supports both of these proposals and would recommend them as part of any technical or incremental changes that may be moving forward later this year.

Conclusion

Thank you for convening this important hearing. We share your commitment to making sure that the Medicare drug benefit reaches its full potential to assist seniors and people with disabilities who need coverage for critical prescriptions.

Statement of the National Association of Health Underwriters, Arlington, Virginia

Relative to Experience with Medicare Part D

(Arlington, VA)—The National Association of Health Underwriters (NAHU) is very puzzled with the GAO report issued this week on Medicare Part D implementation. “The 20,000 members of NAHU are involved on a daily basis enrolling seniors in Part D all across America. Our experience has been very positive, and the service our members report receiving from Medicare.gov and 1–800–Medicare is excellent,” said Janet Trautwein, Executive Vice President and CEO.

“Our members have told us that the people they counsel have been greatly helped by this new benefit, and that they were enrolled with relative ease. Here is just a sampling of some of their responses:

“Being a senior myself and previously without Rx coverage, this is a wonderful thing that all seniors should be elated and telling the world about—it’s the greatest.” Marina del Rey, CA

“The actual enrollment did not take much time and went very smoothly. In fact, I did it later in the day on December 31st—I didn’t want to rush into it! Even though it was so very late, I did not experience difficulties with the enrollment. The Medicare website has continued to evolve. I find it more helpful each time I check into it.” Omaha, NE

“I have enrolled MANY people in Medicare D. Honestly, it is not difficult at all. In the state of North Carolina, we have 16 companies selling Medicare Part D. I studied many of them and picked the companies I felt had good formularies, value for their price, and could help ANYONE from those who are on no medication to people who take numerous medications daily.” Kernersville, NC

“My father, who is 79 years old and just short of 80, went through the process with his retirement trust and it was a breeze for him. He actually started cancer treatment yesterday and needed prescriptions, for which all he used was the letter from Medicare and the pharmacy took the letter with no problem. All went very well.” Tualatin, OR

“I was amazed at just how well the Medicare.gov website worked! There just isn’t any better way to assure you are picking the right plan for the right reasons. Needless to say, I have a great deal of credibility on the line with my clients if the site isn’t accurate.” Corinth, MS

“I speak to people every day who are calling to thank me for saving them money on their scripts. As for the Medicare Advantage plans, those enrollees are saving significant amounts of money. I am seeing a minimum of \$1400/year saved. I see in our future a lot of seniors with more disposable income. To quote Martha, ‘that’s a good thing.’” Lincoln, NE

“... my parents and uncle live in Wyoming. I enrolled them online on December 31. By Saturday, January 7, they had all received their cards and the following Tuesday, January 10, filled some of their prescriptions at the local pharmacy and all went very smoothly. Because of the plan we entered them in, the drugs they received did not cost them anything. They were very surprised and ‘shocked’ as to how easy things went for them.” Larkspur, CO

“I am only on one medication, but I enrolled in a Part D plan as a precaution. It is just like having insurance on my car and my jewelry—I have to have it for myself.” Deerfield, IL

"The daughter of a Medicare beneficiary reports that she consulted with her broker, who helped enroll her mother in the Blue MedicareRx Value Plan. This process went very smoothly and took little time. On January 2, her mother needed to fill a prescription, and the process was very simple as well. Although they did not yet have an acknowledgement letter, the pharmacist verified their information and her mother received her prescription. Her acknowledgement letter arrived shortly afterward. They are very pleased with the savings provided by Medicare Part D—all four current medications are covered and without prescription drug coverage she would pay \$162 for one of the medications alone."

Schaumburg, IL

"Our clients loved it." Orlando, FL

"I have assisted several seniors with this process. I did not find it confusing. The most time-consuming part was determining which vendor offered the coverage best suited to the individual's needs." Maumee, OH

"My grandmother is on a Secure Horizon Medicare plan through PacifiCare in Colorado. I have worked with employee benefits for more than 15 years. When I called my grandmother knowing that I would need to assist, she told me that PacifiCare sent her a letter advising her that she is automatically enrolled and it was already taken care of. Of course I could not believe that it would be so simple. After creating much more work than necessary with several phone calls and finally a conference call, it was true. It was automatically handled. I was amazed and grateful at the same time." Denver, CO

"Any time a new benefit begins where many people are eligible, whether a government program or a private sector offering, there will be initial snags," added Trautwein. "What is amazing is how quickly issues have been addressed, and the high level of enrollment we have already seen in Part D. Our members look forward to continuing our work with beneficiaries on an ongoing basis to be sure they are aware of the wonderful new opportunities in Medicare. Unfortunately, inaccurate reports alleging difficulty in signing up for Part D may discourage people from taking the first step towards protecting their health with coverage for prescription drugs. We hope that in the future more care will be taken before such inaccuracies are reported as fact. The fact is that problem areas were identified early on and were taken care of. The fact is that 30 million people have enrolled in Part D and more are enrolling every day. The GAO report does not apply to the current situation and to characterize it as such is inaccurate and irresponsible."

The National Association of Health Underwriters represents over 20,000 health insurance agents, brokers, consultants and professionals. Our members serve employers and individual consumers in accessing and purchasing affordable health insurance and related products. For more information, please contact Brandi Travis, manager of communications.

Statement of the National Home Infusion Association, Alexandria, Virginia

Chairman Johnson and Members of the Subcommittee, the National Home Infusion Association ("NHIA") is pleased to present this written statement for the record in connection with the Subcommittee's May 3, 2006 hearing on implementation of the Medicare outpatient prescription drug benefit.

NHIA is a trade association that represents and advances the interests of organizations and individuals that provide infusion and specialized pharmacy products and services to the entire spectrum of home-based patients.

As reflected in the testimony presented at the hearing, the new Part D drug benefit already has been providing access to prescription drugs to seniors who had limited or no coverage prior to enrollment in Part D. Notwithstanding some initial implementation problems, as a retail drug benefit, Part D seems to be working fairly well.

One group of beneficiaries who are not being adequately served by Part D, however, is those in need of home infusion therapy. The problem stems from the fact that the Centers for Medicare and Medicaid Services ("CMS") has interpreted and implemented the Part D benefit largely as a retail drug benefit. Unfortunately, the structure that can work well for dispensing pills and other prescriptions at the retail pharmacy level is not feasible for more complex intravenous therapies that require more extensive clinical services, care coordination, equipment, and supplies for proper administration. This is particularly true with respect to home infusion therapy, which private sector health plans typically cover as a comprehensive medical benefit rather than a pharmacy benefit.

What is Home Infusion Therapy?

Home infusion therapy involves administering medications into the patient's bloodstream. It is prescribed when the patient's condition is so severe that it cannot be treated effectively by oral medications. Infusion drugs must be:

- Compounded in a sterile environment;
- Maintained in appropriate conditions to ensure sterility and stability;
- Administered at exactly the right dose and on the right schedule;
- Administered using the appropriate vascular access device (often a long-term device) which is placed in the correct anatomical location based on the expected duration of therapy, the pH, osmolality, and osmolality of the medication;
- Administered using an appropriate drug delivery device;
- Flushed with the proper flushing solution between doses; and
- Monitored for adverse reactions and therapeutic efficacy.

The range of variables that must be managed by the infusion pharmacy to ensure safe and appropriate administration has led commercial payers to treat home infusion therapy as a medical service, reimbursed under their medical benefit (rather than the prescription drug benefit) and paid for using a per diem for clinical services, supplies, and equipment and a payment for nursing visits. It also has led most commercial payers to require that infusion pharmacies be accredited by nationally recognized accreditation organizations. Commercial payers have used this model aggressively to reduce overall health care costs while achieving high levels of patient satisfaction.

Home Infusion Pharmacy Services Differ from Retail Pharmacy Services

To ensure safe and proper administration of infusion drugs as outlined above, home infusion pharmacies provide the following services:

- Comprehensive assessment that considers patient history, current physical and mental status, lab reports, cognitive and psychosocial status, family/care partner support, prescribed treatment, concurrent oral prescriptions, and over-the-counter medications;
- Maintenance of appropriate procedures for the compounding and distribution of sterile infusion products as outlined in the national standards and state and federal regulations;
- Drug interaction monitoring and identification of potential drug, dose or drug-catheter incompatibilities;
- Comprehensive admission procedures that include patient education of medical and disposable equipment use, medication storage and handling, emergency procedures, vascular access device management, recognition and reporting of adverse drug reactions;
- Comprehensive care planning that considers actual or potential drug or equipment-related problems, therapy monitoring with specific patient goals, and coordination of activities with other providers such as home health agencies and physicians;
- Ongoing patient monitoring and reassessment activities to continually assess for response to treatment, drug complications, adverse reactions, and patient compliance;
- Laboratory report reviews, as applicable, and subsequent consults with care professionals to adjust medication orders if necessary;
- Maintenance of appropriate physical facilities for storage, preparation, dispensing, and quality control of all infusion medications and equipment;
- Ongoing employee education and competence validation activities; and
- Performance improvement programs that include collection of clinical outcomes data, patient perception data, trending and analysis of these and other performance measurement data, and root cause evaluations of all sentinel events.

Most retail pharmacies are not designed or equipped to provide all of the above services.

Home Infusion Therapy is not a Good Fit under Part D

CMS's final Part D rule limits coverage of infusion therapy to the cost of the drugs alone and a retail-like dispensing fee. The regulation expressly disallows coverage for the professional services, supplies, or equipment necessary to safely provide home infusion therapy that typically represent more than half the cost of caring for these patients. This fundamental coverage shortfall, as well as the general

inapplicability of the retail benefit design to home infusion therapies, has adversely affected the care of Medicare beneficiaries in several ways.

Dual-eligible beneficiaries typically had full coverage of home infusion therapy under Medicaid prior to their enrollment in Part D. Once enrolled in Part D, however, many dual-eligible beneficiaries initially experienced a disruption in care due to the states' uncertainty as to their role in providing Medicaid "wrap-around" coverage to fill in the gaps left by the drug-only coverage offered by Part D. CMS has been working to clarify the states' role and resolve these issues, which has helped to minimize disruptions in care. However, dual-eligibles continue to be adversely affected by restricted formularies, cumbersome prior authorization processes, inadequate coordination of care, and a lack of access to qualified providers in Part D home infusion networks. These issues have led to unnecessary hospital admissions and hospital discharge delays that continue to this day.

It has been our experience that Part D enrollees who have no Medicaid or supplemental insurance have little or no access to home infusion therapies or qualified home infusion therapy pharmacies through Medicare Part D. Since the non-covered home infusion supplies, equipment, and professional services constitute over 60 percent of the costs associated with home infusion therapy, these Medicare beneficiaries are effectively denied access to home infusion. They are being forced to seek treatment in hospitals and skilled nursing facilities at a significantly higher cost to Medicare and at much greater inconvenience to the patients.

In addition, Part D coverage limitations pose a very real threat to health and safety. There are reports that non-infusion pharmacies have sent non-compounded intravenous drugs by mail to beneficiaries, without educating the patients on how to mix and administer the drug, without any clinical oversight that should be provided based on community standards of care, and without the necessary supplies and equipment that are integral to the drug's safe and proper administration. CMS has been quick to recognize the serious safety concerns and is taking steps to minimize or eliminate these occurrences. While these efforts have helped to address the worst abuses observed during the early weeks of Part D, the root causes of poor quality of care remain intact: a fundamental coverage shortfall, a lack of appropriate quality standards, and an alignment of incentives that do not foster quality patient care.

Since the Part D benefit went into effect on January 1 of this year, the following issues have arisen and remain with respect to the coverage and provision of home infusion therapy under this benefit:

- The absence of coverage for the professional services, supplies and equipment has discouraged the participation of qualified home infusion pharmacies in Part D.
- A disturbing number of PDPs have omitted home infusion drugs from their formularies and have not implemented a timely exceptions process that permits infusion patients who have acute needs to access these drugs.
- Other PDPs are genuinely concerned and frustrated about Part D's incomplete coverage for home infusion therapy and are waiting for CMS or Congress to correct this situation.
- Part D does not provide quality standards applicable to home infusion therapy. Consequently, Medicare beneficiaries are at risk of receiving infusion drugs from entities that do not meet well-established standards of care.
- Many Medicare Advantage enrollees who had comprehensive home infusion therapy coverage under a Medicare + Choice (Medicare Advantage) program prior to January 1 have actually lost this coverage and are now exposed to the same quality and coverage shortfalls as described above.

Proposed Solution:

CMS believes that it does not have the authority to cover infusion therapy services, supplies, and equipment. Yet, CMS acknowledges openly that its policies leave "gaps in coverage" for home infusion. These gaps are jeopardizing patient safety and are actually adding costs to the Medicare program to the extent that patients are forced into more expensive treatment settings or are receiving inappropriate care. As long as Congress allows incomplete coverage of and access to home infusion therapy in Medicare, the program will not realize the efficiencies, cost-savings, and quality improvements employed in the private sector, where home infusion has been utilized and fully covered for decades.

We believe strongly that home infusion therapy coverage should be consolidated under Part B as a separate medical benefit. This can be accomplished through legislation that provides permanent, complete coverage for home infusion therapy under Part B or authorizes a demonstration project to provide such coverage.

Why Part B? Some home infusion drugs already are covered under Part B. Part B was designed to cover multi-faceted therapies and procedures. It is the most logical part of the Medicare program in which to consolidate coverage for home infusion therapy because it could accommodate the various aspects of the therapy—the services, supplies, equipment and drugs. Thus, infusion therapy could be defined and covered accurately under Part B. By contrast, even if Congress were to amend Part D to require full coverage for home infusion, it would remain an awkward fit since the entire Part D administrative apparatus is designed for a drug-only benefit and is not one that can easily be adjusted to accommodate what CMS acknowledges to be a complex medical benefit.

Every day that passes without complete Medicare coverage of home infusion therapy is a missed opportunity to bring cost-effective care in the most convenient setting to beneficiaries. Medicare beneficiaries have a legitimate expectation that they now can obtain home infusion therapy through the Medicare program. We stand ready to work with Congress to fulfill this expectation for our seniors. Thank you for your interest in overseeing and improving the implementation of this important benefit.

National Kidney Foundation, Inc., New York, New York

The National Kidney Foundation (NKF) is the nation's oldest and largest voluntary health agency serving the needs of kidney patients and the health care professionals who care for them. The National Kidney Foundation's clinical practice guideline development program, known as the Kidney Disease Outcomes Quality Initiative, or KDOQI, has facilitated enhanced care for Medicare beneficiaries with chronic kidney disease (CKD). The Medicare Prescription Drug Program should enable Medicare beneficiaries to realize KDOQI recommendations if drug plans provide access to medically necessary treatments for chronic kidney disease.

Chronic Kidney Disease (CKD) affects 20 million people in the U.S., with another 20 million Americans at potentially increased risk.¹ Between 1992 and 2002, the percentage of Medicare beneficiaries with a diagnosis of CKD, including, but not limited to, those who receive benefits under the Medicare End-Stage Renal Disease (ESRD) Program, increased from 3.1% to 6.8%. In 2003, Medicare patients with CKD consumed 23.6% of the Medicare budget.² Moreover, the number of Americans with kidney failure (ESRD) who are treated either with dialysis or transplantation, and, therefore, become entitled to Medicare without regard to age, is expected to increase 85% between 2000 and 2015.³ Oral medications can prevent or slow the progression of CKD to kidney failure, as well as limit the consequences of the complications of CKD (anemia, bone disease, heart disease) for those covered by Medicare who do not yet require dialysis or a kidney transplant to survive. They can also reduce morbidity and mortality experienced by Medicare beneficiaries with ESRD. Therefore, it is important that Medicare prescription drug plans provide affordable access to the spectrum of medications needed by beneficiaries with CKD, so that this Medicare population is not discouraged from enrollment or inclined to disenroll in Part D plans.

The implementation of the Medicare Prescription Drug Program has raised a number of concerns in the kidney community.

Enrollment

One plan has mailed misleading letters to people with ESRD stating they are not eligible to enroll in a stand-alone drug plan because they have ESRD. Although the communication was the result of a programming change in the letter template, patients may assume the letter is correct and discard their enrollment packet and ID card. CMS should approve or reject templates of letters before they can be mailed to applicants and members.

Some people who applied online and have confirmation of enrollment have waited months to learn if applications were approved. Some have been told that computer glitches held up enrollments. Without any Part D ID, these patients have been unable to use Part D to get prescribed drugs. CMS states that plans must approve applications made in one month by the first of the next month. CMS should require plans to track the time it takes them to approve applications made through the Medicare website. This would allow outlier plans to be identified and procedures de-

¹ *K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification*. Am J Kidney Dis 39:S1–S000, 2002 (suppl 1).

² United States Renal Disease System 2005 Annual Data Report.

³ D. T. Gilbertson, et al., Projecting the Number of Patients with End-Stage Renal Disease in the United States to the Year 2015. J Am Soc Nephrol 16: 3736–3741, 2005.

veloped to help them process applications in a timely manner so patients would be able to use Part D when promised.

Some who applied for plans in 2005 received plan IDs and enrollment materials and were using those plans. However, because of facilitated enrollment, they were placed in different plans in April. There should be a better way to cross-check plan enrollment and utilization to avoid enrollments into two plans which could result in disenrollment from the plan the patient prefers.

Some who enrolled in plans and were using them received notice that their plan enrollment was terminated without explanation. No one at the Medicare helpline or the plan could explain why. CMS should require that every disenrollment notice include the reason for disenrollment and appeal rights.

Some people with kidney disease who are dual eligible never received notice of plan enrollment and were not auto-enrolled in plans. Reportedly this related to communications problems between databases. Even with a Medicare ID and active Medicaid cards, they were not enrolled in Wellpoint, the fallback plan, because pharmacists did not know about the fallback plan or did not trust they would be reimbursed. Patients were shuttled back and forth between Medicare and Medicaid without problem resolution. Many were charged full price for drugs that should have been covered by Part D. CMS is working on database communications. There should be alternate ways to communicate with pharmacists since all were not aware of the safety net procedures in place.

Premium Payment

Some people requested that premiums be deducted from Social Security checks. Some who applied in January had never had premiums deducted by May. Many worry that their coverage will be terminated for nonpayment. It would help if people could be notified that their request for deduction of premiums had been received. Also, CMS provided information indicating that only a maximum of three month's premiums would be deducted and that plans could bill if outstanding premiums covered a longer period of time. There should be some assurance that duplicate payments will not result.

Part B vs. Part D issues

Pharmacists continue to have difficulty knowing whom to bill for immunosuppressants needed to prevent rejection of transplanted organs and when to bill Part D or whether they should bill Part B. Doctors should be encouraged to write Part B or Part D on prescriptions to help pharmacists. If a drug is covered by Part D, the pharmacy should bill Part D. However, if the drug is covered by Part B and the pharmacy does not have a Medicare provider number to bill Part B, CMS should require the pharmacy to tell the patient to consult with his/her transplant program about where he/she can get drugs under Part B rather than trying to bill Part D. Problems with Part B vs. D have placed patients at risk of losing transplants due to delays in getting essential immunosuppressants.

Drug Utilization Limits

Prior authorization requirements have been imposed on Medicare beneficiaries who have received solid organ transplants and are entitled to Part D coverage for immunosuppressant medications. This has occurred despite the promise of access to all or substantially all of these immunosuppressant drugs under Part D. Prior authorization has placed a paperwork burden on busy physicians and created delays in patient access to essential medications. Plans should have to abide by the requirement that those who have been treated with these medications under Medicaid drug programs or with other third-party payment should not be subject to prior authorization requirements.

Excluded Drugs

The statutory exclusion of prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations, has proved problematic. Oral iron is needed by patients with CKD, other than in-center dialysis patients, to treat the anemia that accompanies chronic kidney disease. (In-center dialysis patients receive iron supplements intravenously.) Dialysis patients need special vitamins because dietary restrictions limit their intake of essential vitamins and minerals, the dialysis procedure removes essential vitamins and minerals, and because most standard vitamins contain high levels of fat soluble vitamins and certain minerals that rise to toxic levels in people with impaired kidney function.

Formularies

Not all plans provide coverage for the spectrum of medications that are effective in addressing problems of bone and mineral metabolism experienced by Medicare

beneficiaries with CKD. Disturbances in mineral and bone metabolism are common in patients with CKD. These patients have bone pain, increased incidence of bone fractures and deformity, myopathy and muscle pain and ruptures of tendons. Elevated blood levels of PTH exert significant adverse effects on the function of almost every organ and may require parathyroidectomy. Furthermore, there is growing concern about the long term effects of these derangements on soft tissue calcification. All of these conditions can be managed with appropriate pharmacological interventions but clinicians must have access to as wide an array of medications as possible to individualize therapy for these multiple conditions and avoid harmful drug interactions.

CMS Formulary Guidance

CMS has published guidelines that the agency will use in reviewing prescription drug plan formularies and procedures and thus, fulfill the requirement of the Medicare Modernization Act to assure that drug plans do not discriminate against any particular types of beneficiaries. However, CMS needs to operationally define when enrollment is considered to be “substantially discouraged” as well as develop a program to identify and compare actual Part D enrollment by beneficiaries with CKD as opposed to expected enrollment. Furthermore, CMS should track formulary changes, including drug utilization limits affecting beneficiaries with CKD during the course of the benefit year, as well as the number of beneficiaries with CKD who drop out of the program.

The following comments concern the draft formulary guidance that CMS published in March, 2006.

P & T Committee Review

Because of the size of the Medicare population with CKD, and the extent of Medicare program expenditures associated with this condition, there should be a requirement that P & T committees include members with expertise regarding the pharmacological needs of kidney patients.

Drug List Review

- Problems of access to the drugs that prevent transplant rejection were noted above. Unfortunately, the CMS formulary guidelines for 2007, as drafted, will not resolve these problems. While the relevant section on page 7 of these draft guidelines, reads as follows: “CMS will continue to require Part D plan formularies to include all or substantially all (immunosuppressants),” on page 4 it is stated that, if a USP formulary key drug type is primarily covered under Part B, CMS will not expect these drugs to be represented on formularies. (Immunosuppressants are primarily covered under Medicare Part B.) Finally, on page 3, it is stated that plans that use a classification system that is consistent with USP’s will have a safe harbor. Regrettably, USP has deleted immunosuppressant drugs for transplant recipients from its model formulary for 2007. Unless these inconsistencies are addressed, transplant recipients enrolled in Part D will continue to experience problems in accessing the drugs they need to protect their transplants and avoid the need for re-transplant. Immunosuppressants, and other drugs that are primarily covered under Part B, must be included in Part D formularies in order to minimize confusion and insure that patients will not be placed in a life-threatening situation when their prescriptions cannot be filled.
- CMS should utilize the analysis of the USP model formulary that was developed by ESRD Network 8 in evaluating whether plans are providing appropriate access to necessary drugs for those with kidney disease and kidney failure, including those with kidney transplants.
- Formularies should contain separate pharmacologic classes for fixed dose combinations of antihypertensive drugs to promote adherence of patients to regimens that can prevent or delay the progression of chronic kidney disease and/or its complications.

Prior Authorization, Step Therapy, and Quantity Limits

Plans should be reminded that once a request for coverage determination is approved, it covers the plan year, as long as the doctor prescribes the drug, the patient takes the drug, and the patient is still on that plan. Some plans are requiring doctors to provide prior authorization multiple times per year.

Long Term Care Accessibility

With regard to accessibility for Medicare beneficiaries in long term care facilities, many of these patients require unit dose packaging and CMS should require PDPs/MA-PDs to make this service available.

Conclusion

Thank you for the opportunity to provide these comments on the implementation of the Medicare prescription drug program. The National Kidney Foundation is available to assist the Centers for Medicare and Medicaid Services in developing strategies to assure that Medicare beneficiaries with chronic kidney disease have access to high-quality, cost-effective drug coverage.

*Mill Creek, WA 98012
May 1, 2006*

Dear Committee Decision Makers:

I wish to state my total opposition to the implementation of this egregious legislation that does not guarantee “best drug pricing” negotiations, customer flexibility or reasonable customer choice and which seems meritorious only to the pharmaceutical and insurance companies! This legislation was also improperly and possibly even illegally brought to fruition in a manner that in itself warrants investigation and negation of this legislation! I urge reconsideration of this benefit as a whole with new drug pricing negotiating legislation included at a cost which is more in line with what was presented & voted on (but inaccurate & woefully (possibly criminally) misrepresented) at the time.

Sincerely,

Toniann Reading

Statement of Elena Rios, National Hispanic Medical Association

Congresswoman Johnson and the Members of the Subcommittee on Health, Ways and Means Committee, it is an honor to provide testimony to discuss the Medicare Part D program and its impact on the Hispanic community.

I am representing the National Hispanic Medical Association, a non-profit organization representing licensed Hispanic physicians in the U.S. The NHMA mission is to improve the health of Hispanics and other underserved. We believe that the Medicare Part D program represents a major step forward in expanding Medicare and in improving quality of life for American elderly and other eligible beneficiaries.

We are here today to discuss the continued concerns from NHMA that need to be addressed to improve the implementation of Medicare Part D in order to increase access to prescription drugs for Hispanic beneficiaries.

Medicare represents 43 million Americans who need help in moving to the new Part D Drug Plan by May 15, 2006—84 percent White, 7 percent Black, 6 percent Hispanic, and 3 percent for all others. Among the disabled, 11 percent are Hispanic. At this point, we also need help in reducing the penalties for not enrolling by this deadline, which will become a deterrent to many.

As we know from the Agency for Healthcare Research and Quality Health Disparities Report, Hispanics have the worst record when it comes to indicators for access to health care services, in general. Thus, we can expect that our community requires extra attention in the implementation of health programs in order to increase use by the group.

What is key for Hispanics is first, they are a group with low rates of enrollment in Medicare compared to Blacks and Whites. They have the greatest proportion of lack of insurance in America and, thus, as a group, have major challenges for the system to include them in any health care service.

Some of the challenges that we must address for Hispanics include low educational attainment and low literacy rates; less ability to follow drug label instructions; the strong Spanish language use; the importance of culture and health beliefs; the lack of trust of the system and the lack of awareness of the public health programs and healthcare services in general; the critical lack of Hispanic physicians and healthcare providers; and the importance of Latino community-based services for information.

In terms of access to needed medical care, enrollment in Medicare and now Part D, is key for disabled Latinos and, especially, for the elderly Latinos with multiple chronic diseases—diabetes, heart failure, ESRD, cancer, glaucoma, Parkinson’s disease, Alzheimer’s disease, etc.

Hispanics also represent the largest immigrant group in the U.S. One in nine U.S. residents is foreign born, one in seven workers is foreign born, as is one in four low-wage workers. The Urban Institute recently released an eight year study on “Assessing the New Federalism: Eight Years Later” and studied immigrants vs. non-immigrants. It found that immigrant families participate at a substantially lower level than their native counterparts in such benefit programs as TANF, food stamps, and housing assistance. After welfare reform, benefit use declined not only among legal immigrants whose eligibility was restricted by the law but also among refugees, citizen children, and other populations whose eligibility was not restricted. Given the new interest from Congress in immigration reform, there is a critical need to include health care education and enrollment for immigrants into health care services.

The MMA Law has major challenges—a major one being the transition of the 6.1 million Dual Eligibles, with a third being Hispanic and 62% of those are under 150% of Federal poverty level, relying only on Social Security. Despite planning for the past year of CMS and the States, we now know about several glitches that have occurred with the transition of Dual Eligibles to Medicare drug plans—some due to technology and staff errors and some due to the inadequate customer service and some due to the challenges of Hispanics and health care.

CMS reports that even after successful application, there are problems identified in processing the applications—with only one in four applications for Low Subsidy Benefit being successfully executed, delaying the enrollment from our communities further.

Literature shows the impact of Medicare and Medicaid drug prescriptions with minorities:

1. Medicaid Managed Care and Racial Disparities in AIDS Treatment, Health Care Financing Review, 2004, showed Blacks still face barriers in access to care, even after Medicaid assured financial access—under both FFS and managed care.
2. Racial and Ethnic Disparities in Prescription Coverage and Medication Use, HCFR, 2003, showed that with Hispanic and Black Medicare beneficiaries without drug coverage used 10–40 percent fewer medications than Whites with the same illness, and spent up to 60 percent less in total drug costs.
3. The same study showed that Medicare beneficiaries with the same disease and type of prescription coverage found that minorities tend to get less of chronic medication compared with Whites.
4. The same study showed that Hispanics tended to use more expensive drugs which might be an example of loyalty to brands.

Literature about Medicare and minorities with a focus on the ESRD program:

5. Daumit study of 1999 was an analysis of patients who gained Medicare coverage through the ESRD program and found a three-fold difference in the use of clinical procedures by patient ethnicity nearly disappeared following the acquisition of the special ESRD Medicare coverage.

Medicare Part D

Despite the plan to have at least two drugs in each class provided to patients in a drug plan; pharmacy and therapeutic committees, CMS evaluation of formularies and benefit management tools, there are major areas of variance for all Medicare beneficiaries:

- Prescription drugs covered
- How much you have to pay
- Which pharmacies you can use

Dual Eligibles plan included random enrollments in plans, with more chance for mismatch of needed meds.

CMS is to be commended for its Hispanic media outreach efforts—targeting Hispanic dense metropolitan areas and working with national and local partners as well as the coalition development that NHMA is involved in. NHMA is also working in partnership with United Health Group/Ovations and mailed Medicare Part D information to 33,000 Hispanic physicians.

But NHMA has continued to receive many calls from physicians having problems with the transition of dual eligibles, confusion of our community elderly. Two examples from San Diego area—Ophthalmologists in private practice—From January 3rd to 6th—129 dual eligible patients were seen and 60% were in drug plans that did not cover their ophthalmic medications. A cancer patient was refused her pain medication by the new drug plan which would have resulted in fatal drug withdrawal.

Another issue from callers includes the lack of ability of small pharmacies in our communities being able to compete with the chain drug stores using their branding on labels for the Medicare Part D benefit prescriptions. Latinos have thought they could only go to these chain drug stores now.

Thus, CMS and its partners need to do more comprehensive education and reinforcement of marketing to increase enrollment in our hard to reach communities, especially minority and the poor.

RECOMMENDATIONS

1. Research on prescription medications and Hispanic patterns of use
 - a. Closing the gaps in medication use by race and ethnicity—it becomes important to study the extent to which the differences are due to provider or beneficiary behavior amenable to change
 - b. Loyalty to brands for Hispanics and drug plan selection
 - c. Affordability and simple enrollment procedures
2. Build upon the CMS public health campaign to correct misperceptions about the importance of treatment adherence, targeted to Hispanics
3. Increase culturally designed education media programs with Spanish media
 - a. About the importance to enroll in Medicare Part D managed care vs stand alone plans—need to be discussed in detail with our communities
 - b. How to use medications and how to use them as a part of your daily activities
 - c. Identify activities that work and share them
4. Support demonstrations with Hispanic physicians and patient communication and compliance and lessons learned for the non-Hispanic physicians and providers in our communities
5. Train public health leaders about Hispanics and health, based on this Medicare experience
6. Require cultural competency in licensure CME and encourage more physicians to understand Hispanic patient needs, challenges
7. Health care facilities—hospitals, nursing homes need standards for cultural competence and language services and use of community workers to help with education (promotoras)
8. Include new efforts at developing symbols on signs (“Hablamos Juntos” RWJF program) for LEP patients in Medicare Part D program development
9. Reforms needed—
 - a. Dual Eligibles need a longer transition with monitoring and report to Congress on the progress and the challenges to address
 - b. Simple co-payments messages needed and less variability in “basics” with drug plans—to decrease the confusion for elderly
 - c. Formulary monitoring at the Federal level—couldn’t there be a direct pharmaceutical company to Medicare “stockpile” that can provide medications to be purchased by the drug plans for extra drugs needed that were not on their formulary (to decrease patients falling through the cracks due to glitches in the system)
 - d. Pharmacies should be able to continue dispersing without drug plan coverage, allowing for the transition issues—perhaps with a monitoring by the Federal Government
 - e. Eliminate penalties for those who didn’t enroll by the May 15th deadline
10. Quality of care—needs to include incentives to make the system more responsive to Hispanics and their families.
11. Increase outreach payments for rural, inner city and teaching hospitals and other safety net providers
12. Consider the programs that could be developed in Medicare GME funding—Incorporate Medicare information into medical education so that residents and medical students can explain the program to patients.
13. Lastly, the Office of Minority Health at DHHS should increase the participation of all national minority health organizations with the effort and link CMS education efforts at their national conferences, websites, newsletters, etc. More community help is needed in addition to the phone hotlines and online counseling supported by CMS to outreach to Hispanics about Medicare Part D.

References

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 Urban Institute New Federalism Report, 2005
 Health Care Financing Review articles on racial disparities with Medicare, CMS searches.
 CMS Hispanic Media Project Fact Sheet, January 17, 2006
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West Valley City, Utah 84170
 May 2, 2006

This statement is meant to clarify for the Committee on Ways and Means the horrendous and confusing chaos caused by the recent implementation of the Medicare Drug Benefit Program, and to beg the Committee's review and recommended revision of the Medicare Drug Benefit Program so that it benefits the people it was meant to help, rather than the drug companies and the insurance sellers who are currently cleaning house at the expense of the U.S. Government and the Medicare Trust Funds.

Currently, the Medicare Drug Benefit Program is so desperately fragmented and unreliable because the Plan does not allow control by Social Security or Medicare, but rather allows private insurance companies and drug entities to set the rules and the standards under which this huge and complicated program is run. Instead of placing this program under the responsibility and control of the government agencies footing the largest portion of the bill, the Administration simply opened the doors to private contractors who cannot or will not take responsibility for the responsible handling of the program in a manner that satisfies the public need.

Billions of tax dollars are being poured into this program, but the public continues to suffer indignities and hardships because in passing this law, the Administration took away many of the excellent drug benefit plans many seniors and disabled persons enjoyed, and laid in their place this convoluted, incomprehensible, and unreliable program that has left a large number of its intended beneficiaries without drug coverage for months on end, without the simple ability to contact Medicare or SSA to straighten out simple technical problems, and without any support system to help them find their way through this mess!

I see the way this program works because I am involved in a very intimate way with the people it so greatly affects (and disadvantages). I am a front line service representative for the Social Security Administration, and have worked in this capacity for over a quarter of a century. In the entire time I have worked with SSA and Medicare, I have never before witnessed a more ridiculous, incomprehensible and just plain stupid set of circumstances as this new Medicare Drug Benefit Plan presents.

Medicare and Social Security have been the cornerstones of the programs that seniors, survivors, and disabled persons have come to rely on over the past seventy years; a grouping of beneficial programs run by responsible federal employees who have been thoroughly trained in the concepts of the body of laws governing the programs. People have come to respect and trust those of us who administer these programs, and now they have come up against a new "Medicare" program like none other before it . . . geared to the profiteering of large companies who see another way to suck billions of dollars off the current Administration's desire to "contract out" government activities.

It is a free-for-all, clear and simple, and now our elderly and disabled beneficiaries are actually receiving confusing, unwelcome solicitation calls from these companies, frightening them and confusing them all in the hopes of getting a new customer to buy their product. I speak with dozens of people a day who come to Social Security and wait an hour or two in our waiting rooms in an attempt to "get this mess straight". But SSA does not have any input into this mess, because we are not in the loop. We are told to refer these poor souls to 1-(800) Medicare. (Or the drug insurance providers.) These people come to us because we are the ones who have always been there to fix the messes, but we can't fix this. And we can't do anything but point them along to another source.

I have called Medicare in behalf of dozens of these poor souls who, in their 80's or mentally unable to cope with confusion, are forced to call a voice-recognition call answering machine that "sorts" the calls by category, and forwards the calls to the "proper component". I have called the 1-(800)-MEDICAR number, and managed to

get through to the lines, then I am sent to a “disenrollment specialist” line, where I am told “call counts are currently heavy. Please call back at another time”. Or, after going through fifteen minutes of talking to a computer, I am sent to a “problem specialist” who tells me that she will “e-mail CMS Regional Office” with the problem, because she has no way to help the person, since she is simply a call center employee who cannot take any action or give any real answers, and we must wait three to five days for a Medicare person to call the beneficiary back.

If this is the service that Medicare is currently giving to these persons, I can see why they are crowding into SSA offices to try to get help which we cannot render.

I feel that the new program drops the ball completely. There is nothing but “buck-passing” happening between the Medicare call centers and the providers. Since SSA is not even in the loop here, I am amazed that these people have the temerity to tell beneficiaries that they must contact SSA when the drug premiums are deducted from their Social Security checks after they have already paid the premiums by personal check after receiving a threat that they will be disenrolled for non-payment.

Under this program, Medicare sends SSA notice to begin deducting premiums from checks, (which is about our ONLY involvement here) while the drug insurance providers are busily sending bills to the beneficiaries for the very same premiums! SSA cannot do anything but continue to deduct the premiums until CMS orders us to stop. We now hear that it is taking CMS up to 90 days to change enrollments for people who are not satisfied with the providers, or cannot get the drugs they require from the providers. In the meantime, we are still taking premiums out for the OLD provider, while the beneficiary is being billed for services from the NEW provider. (And neither provider is furnishing the expected discounts.)

Many times, the providers have been changed without notice to the beneficiary, and these poor folks cannot get their prescriptions from either provider! I have had many elderly beneficiaries tell me that they have gone without life-preserving drugs for up to three months at a time because “something” was wrong with their enrollment information, or the provider did not have them listed, or what-have-you. When I have called the drug Program provider shown on our records from CMS, the provider simply says, “We don’t have proper authorization and we cannot give them their drug discounts until CMS gets the computer records fixed”. Calling CMS results in the answer “the provider is not giving us the proper information”.

This is the MOST irresponsible way of handling the Medicare Drug Benefit Program that could possibly have been hatched by a bunch of people who have absolutely NO concept of what they are doing.

Instead of giving this program to SSA, and saying “make it work,” the Administration simply handed it over to the private sector, and the bidding wars began. And only after the program bankrupts the Medicare trust funds will the Administration admit that this was not such a neat plan, after all. Perhaps there will be a new Administration in place when that happens, and we can start over. Hopefully the American people will not have been completely fleeced by that time, and there will still be a trust fund to rely on.

Yes, there is a great need for this program, BUT NOT AS IT IS NOW. The American people deserve better treatment. We do not need a program that uses taxpayer’s money to further subsidize the profits of huge drug companies and insurance providers. They make enough profit with their price gouging as it is!

The VA dickers with drug companies over the prices they must pay for medicines for the millions of veterans they serve. Medicare is not allowed to do that. Before this new program, many drug companies were expected to give a percentage of FREE drugs to millions of Americans on limited income. Now they can make money off these needy folks by billing the government for the same drugs they once gave for free. This is a program crafted by profiteers for other profiteers. It is a travesty of what it should be.

I know that this is not the time for semantics and emotions, but it IS the time for a realistic review of the inadequacies and disappointing inequity of this huge and expensive pork barrel. It is time to listen to the people this program is so greatly affecting, and turn the reins over to a tried and true administration whose employees have been handling social insurance programs for nearly three quarters of a century, and who have no personal interest in making a quick profit at the taxpayers’ expense.

Get this program into the proper hands, and get it running right! Give SSA the people they need to run it, and you will find that it can be run in a manner that will make sense, and have a positive impact on the people it was meant to serve, by cutting out the confusion, the waste, and the sheer ponderous stupidity of it all.

You are all well aware (or you should be by now) that SSA’s overhead expenses are less than 1% of income. What private organization can boast that kind of conservatism? In this age of pushing for “smaller government,” the Administration is

gearing the system for disaster. Touting to the public that private industry can handle this type of program better than seasoned government agencies is like shouting out that wolves make the best babysitters!

So please take this opportunity to scream for help. And scream in the right direction, because the wolves are at the door here, and the babies need your intervention!

Thank you for considering this statement. I trust that you will open your minds to this information, and present it in the near future to those who need to hear from private citizens, and not just big business interests.

Frances Romney

Sandy, Utah 84094
May 3, 2006

Distinguished Members of Congress:

I am 69 years old and hold a PhD. from MIT. The last bit of information is provided as some indication that I can probably understand and digest difficult concepts.

I have attended five presentations for seniors by insurance companies. These presentations were advertised as being about Medicare Part D drug plans they offer. There are about 40 such plans offered in my area, so I've barely been able to scratch the surface. In each case 10 percent or less of the presentation was about the drug plans offered. The remainder was a pitch for the company's Medicare Advantage Plans, some of which include drug coverage and some of which do not. The point here is that the insurance companies are using Medicare Part D as a lure to get seniors to buy their Advantage Plans. That is not terribly surprising in the world of "privatization."

As these presentations continued through the touted Advantage Plans seniors were confronted with perhaps hundreds of data points—copayments, deductibles, network participants, formularies, out-of-network coverages, etc.—most of which differ from one plan to another. Seniors are inundated with numbers, most of which have little to do with the drug coverages offered, or not offered, by the insurance companies.

I understand that you, as members of Congress, have excellent health benefits. But even those seniors who have never been elected to Congress have little or no experience in comparing health insurance plans. That was usually done for them by their employers. As it is presented, the amount of data that appears to have to be absorbed to make an intelligent choice (an underlying cornerstone of the free enterprise system in action) is overwhelming.

I implore you to at least give seniors more time to make a choice of a Medicare Part D plan without being penalized. A better solution would be to fold the entire prescription drug coverage under traditional Medicare and use the buying power of the Medicare program to negotiate lower drug costs with the drug manufacturers. As far as I can tell the insurance companies have only been negotiating with pharmacies, not manufacturers.

Thank you.

Arthur Sutherland

